GRACE MANOR PRESCRIPTION MEDICATION LOG

Child's Name: _____ Physician's Name: _____
Pharmacy Name: _____ Pharmacy Phone #: _____
Name of Drug: _____ Strength & Dosage: _____
Amount Received: _____ Date Filled: _____
Directions: _____

Signature of Person Administering Meds (initial after signature)	DATE	TIME	AMOUNT GIVEN	Signature of Person Administering Meds (initial after signature)	DATE	TIME	AMOUNT GIVEN