Name: _____ Month/Year: _____

Known Allergies/Sensitivities: Diagnosis: _____

_____

Christian Heritage Medication Log

DAY OF MONTH

HOUR GIVEN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
START DATE: _____																															
MEDICATION NAME/STRENTH: _____																															
☐OTC ☐PRN Rx#: _____																															
DOSEAGE:_____																															
ROUTE: _____																															
DOCTOR: _____																															
START DATE: _____																															
MEDICATION NAME: _____																															
☐OTC ☐PRN Rx#: _____																															
DOSEAGE:_____																															
ROUTE: _____																															
DOCTOR: _____																															
START DATE: _____																															
MEDICATION NAME: _____																															
☐OTC ☐PRN Rx#: _____																															
DOSEAGE:_____																															
ROUTE: _____																															
DOCTOR: _____																															

Name & Initials of Persons Completing Form	
Name (Please type or print)	Initials

CHRISTIAN HERITAGE

Key			
Medication:			
Missed	M	Respite/Away	A
Refused	R	Wrong Time	Time/Initials
Given at School	S	As Needed	Time/Initials

_____

Staff Member Signature/Date

Notes/Documentation: