ASTHMA MEDICATION RECORD

NAME OF CHILD: _____

NAME OF EDUCATOR: _____

To be completed by the Educator and initialed by the parent/guardian on each day that medication is administered.

Day/Date of Administration	Name of Medication	Dosage amount (as per action plan)	Time and Educator signature- Initial Dose	Time and Educator signature- Subsequent Doses	Method of Administration (eg. Inhaler)	Medication administered by: *Educator *School Age Child *School Age Child with educator assistance.	Parent initial to acknowledge administration
Day: **Date:**							
Day: **Date:**							
Day: **Date:**							
Day: **Date:**							
Day: **Date:**							
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Day: **Date:**							