BEACON OF HOPE
MEDICATION LOG

Child's Name: _____

Date Filled: _____

Month/Year: _____   Physician: _____   Amount Dispensed: _____

Reason for Medication: _____   Pharmacy: _____

Medication->								
Quantity->								
Dosage->								
Day->	Time	Initials	Time	Initials	Time	Initials	Time	Initials
1	AM PM		AM PM		AM PM		AM PM	
2	AM PM		AM PM		AM PM		AM PM	
3	AM PM		AM PM		AM PM		AM PM	
4	AM PM		AM PM		AM PM		AM PM	
5	AM PM		AM PM		AM PM		AM PM	
6	AM PM		AM PM		AM PM		AM PM	
7	AM PM		AM PM		AM PM		AM PM	
8	AM PM		AM PM		AM PM		AM PM	
9	AM PM		AM PM		AM PM		AM PM	
10	AM PM		AM PM		AM PM		AM PM	
11	AM PM		AM PM		AM PM		AM PM	
12	AM PM		AM PM		AM PM		AM PM	
13	AM PM		AM PM		AM PM		AM PM	
14	AM PM		AM PM		AM PM		AM PM	
15	AM PM		AM PM		AM PM		AM PM	
16	AM PM		AM PM		AM PM		AM PM	
17	AM PM		AM PM		AM PM		AM PM	
18	AM PM		AM PM		AM PM		AM PM	
19	AM PM		AM PM		AM PM		AM PM	
20	AM PM		AM PM		AM PM		AM PM	
21	AM PM		AM PM		AM PM		AM PM	
22	AM PM		AM PM		AM PM		AM PM	
23	AM PM		AM PM		AM PM		AM PM	
24	AM PM		AM PM		AM PM		AM PM	
25	AM PM		AM PM		AM PM		AM PM	
26	AM PM		AM PM		AM PM		AM PM	
27	AM PM		AM PM		AM PM		AM PM	
28	AM PM		AM PM		AM PM		AM PM	
29	AM PM		AM PM		AM PM		AM PM	
30	AM PM		AM PM		AM PM		AM PM	
31	AM PM		AM PM		AM PM		AM PM	

SIGNATURE(S) OF PERSON(S) ADMINISTERING MEDICATION: _____

Each set of initials should have a corresponding signature