Administration of Medication Record

STUDENT INFORMATION		
Student's name:		School name:
Date of birth (mm/dd/yyyy):	Grade:	Homeroom teacher:
Place Photo Here	Signed copy of *Authorization Form and Directions for the Administration of Medication(s)* attached: ☐ Yes	

PARENT/GUARDIAN		
Name(s) of parent(s)/guardian(s):	Emergency number:	Email:
Name(s) of parent(s)/guardian(s):	Emergency number:	Email:

SCHOOL STAFF ADMINISTERING AND/OR MONITORING MEDICATION		
Name	Signature	Initials

STUDENT NAME: **SCHOOL YEAR:**

NAME OF MEDICATION: **MEDICATION EXPIRY DATE:**

NOTE: Double-check every time that you are giving the correct student the correct medication and dose at the correct time and that you complete the documentation immediately. A separate Administration of Medication Record is required for each medication.

Date (dd/mm/yyyy)	Dose	Time	Route	Administered By	Witnessed By (as applicable)	Additional Comments

Completed sheets and attached information are to be retained together for the current school year.
Photocopy this blank page as needed.