Administration of Medication Record

School Year: 20 to 20

STUDENT INFORMATION

Place Photo Here (when available)	Student name:		School name:
	Date of birth (mm/dd/yyyy):	Grade:	Homeroom teacher:

Signed copy of the *Authorization and Directions for Administering Medication(s) at School form* is attached: ☐ Yes

ALL INFORMATION FIELDS IN THIS FORM ARE REQUIRED TO BE COMPLETED, SO STUDENT ID CAN BE CHECKED AND MEDICATION SAFELY ADMINISTERED.

PARENT/GUARDIAN INFORMATION

Parent/guardian name:	Emergency number:	Email:
Parent/guardian name:	Emergency number:	Email:

SCHOOL STAFF ADMINISTERING AND/OR MONITORING MEDICATION

Name	Signature	Initials

Student name: **School year: 20 to 20**

Name of medication: **Medication expiry date:**

Quantity of medication provided to the school (Number of tablets or volume of liquid medication):

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 this documentation immediately. A separate Administration of Medication Record is required for each medication.

Date (mm/dd/yyyy)	Dose	Time	Route	Administered By (initials only)	Second Checker (as applicable)	Additional Comments

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