RECORD OF THE ADMINISTRATION OF MEDICATION

Name of Student: ____________________

Parents' Phone Number: ____________________ Grade: __________

Medication: ____________________

Date to Begin: ____________________ Date to End: ____________________

Dosage: ______ Method: __________ Time: __________

Prescriber or person authorizing administration: ____________________

Phone #1: ______ Phone #2: ____________________

Possible Adverse Reaction: ____________________

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Person(s)
Authorized to
Administer
Medication:. ____________________

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Date Given	Time	Dosage Given	Signature of Employee Administering Medication and Title/Position	Comments