ADMINISTRATION OF STUDENT MEDICATION

Student's Name: _____ **Class:** _____

Medication Name & Dosage:

1. _____
2. _____
3. _____

Additional Information:

_____

_____

_____

Parent's Signature: _____ **Date:** _____

Staff Member's Signature: _____ **Date:** _____

Medication Administered Name & Dose	Date	Time	Staff Member's Signature	Counter Signature

Parent's Signature on pick-up:_____