Conseil scolaire du NORD-OUEST

DA 313B - ANG

MEDICATION ADMINISTRATION RECORD

Student Name : ____

Name of medication : ____

Dose (amount of medication to be administered at a time): _______________________________

Period that the medication will be administered: ______________________________________

From : (day/month/year) ____________________ To: (day/month/year) _____________________

Symptoms/Reactions related to the medical condition:

____

____

Precise time (hour) at which the medication is to be administered: ___________________________

Special Warning/Precautions: ____

____

Parent/guardian Signature : ____

Medication Administration Record

***To be completed each time the medication is administered.**

Date	*Medication (name)*	*Dose*	*Time*	*Administered by (signature of employee)*

Record of Medication Administration

To be completed each time the medication is administered.

Date	*Medication (name)*	*Dose*	*Time*	*Administered by (signature of employee)*