School Year: _____

MEDICATION ADMINISTRATION RECORD

Name of Student:		
Name of Medication:		
Dosage:	Route: *(ex. oral, drops, topical, etc.)*	Time(s) of Administration:

*Prior to administering medication, ensure that you have reviewed the *Authorization for the Administration of Prescribed Medication* form with your administrator (or designate).

DATE	TIME	COMPLETE (initial)	INCOMPLETE (indicate reason: absent/ refused/missed/error/etc.)	STAFF MEMBER (name)

Version: February 2022

Educational Care & Excellence

School Year: ____________________

DATE	TIME	COMPLETE (initial)	INCOMPLETE (indicate reason: absent/ refused/missed/error/etc.)	STAFF MEMBER (name)