Administration of Medication Record

Sheet number……. (in chronological order)

School		
Name of Child		**DOB:** **Class/form:**
Name of medication		**Formula** e.g. tablets, liquid
Quantity received from parent		
Quantity returned to parent		
Dosage and times		
Any special instructions		

Date & time of administration	Dose given	Any reactions and any action taken by staff	Name of person(s) administering / supervising *(please print)*	Signature of persons administering / Supervising (2 staff members, eg admin and TA/Teacher) If admin not available, please inform office asap	Additional information e.g. • Repeat prescription supplied • Medication returned to parent • Medication returned to pharmacy (Pharmacist signature required) • Parents signature (Early Years Children only)