

FORM – 3.5.2 STUDENT MEDICATION ADMINISTRATION LOG

STUDENT INFORMATION

Student Name: _____ Date of Birth ____/____/____

School: _____ Grade: _____

Teacher: _____

Parent/Guardian Name: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact Name & Phone #:

MEDICATION INFORMATION

Medication Name: _____ Dosage: _____

Route of Administration (e.g., oral, inhaled, injected):

Time(s) to be Administered at School:

Start Date (DD/MM/YYYY): ____/____/____ End Date (DD/MM/YYYY): ____/____/____

Reason for Medication: _____

Possible Side Effects: _____

MEDICATION ADMINISTRATION RECORD

[illegible]

NOTES & INCIDENT REPORTING

- Any missed doses, adverse reactions, or concerns must be documented in the notes section and reported to the parent/guardian and school administrator immediately.
- If emergency medical attention is required, follow the school's emergency procedures and notify parents/guardians promptly.
- Ensure all records are maintained in accordance with school policies and privacy regulations.

SIGNATURES**School Personnel Responsible for Medication Administration:**

Name: _____ Signature: _____

Date (DD/MM/YYYY): ____/____/____

Parent/Guardian Signature:

Signature: _____ Date (DD/MM/YYYY): ____/____/____