Annapolis Valley
Regional Centre for Education

AP 401.10-1l
Administration of Prescribed Medication Record

Student Information:

Name: _____ DOB (dd-mm-year): _____

Parent(s)/Legal Guardian(s): _____

Home Phone: _____ Emergency Phone: _____

Name of Prescribing Health Care Professional: _____ Phone: _____

School: _____ Grade/Homeroom Teacher: _____

Medication to be Administered/Monitored by:

Name: _____ Signature: _____ Initials: _____

Name: _____ Signature: _____ Initials: _____

Name: _____ Signature: _____ Initials: _____

Date (dd/mm/yyyy)	Medication	Dose	Time	Route	Administered by (initials)	Witness (where applicable)