ANNAPOLIS VALLEY REGIONAL SCHOOL BOARD
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)

Please copy this page as necessary. Page _____ of _____