Administration of Prescribed Medicine to Students

Student	
Name:	
Class:	

Parent/Guardian	
Name:	
Signature:	
Contact Phone No:	
Relationship to student:	

Medication requirements	
Condition:	
Treating Doctor:	
Doctor Phone No:	
Pharmacist:	
Pharmacist Phone No:	
Medication Name:	
Method of Administration	

Date	**Dosage**	**Medication Administration Time**	**Name of Administrator**	**Signature**

Catholic Education Acknowledgement	
Principal Signature:	
Date:	

Completion	
Date of Completion	
Unused medication returned to parent?	
Name of Administrator	
Signature	

Copy to be given to Parent/Guardian.
Original to be retained in student file.