St Mary's Catholic Primary School

Medication Administration Record

Date:____________________ Student Name:____

Medical Instructions *(completed by parent/guardian)*

Medication Name:____

Dose/amount:____

Time to be administered:____

Method of administration:____
(e.g. oral, inhalation, injected, crushed, with water)

Extra Notes:____

Signature Parent/Guardian:____

Administration Record *(completed by staff)*

Date	Medication	Dose	Time	Staff Member One (name and signature)		Staff Member Two (name and signature)	