MEDICATION ADMINISTRATION LOG

One form to be completed for each medication.

Student_____**Date of Birth**_____

School Year _____**School** _____**Grade** _____**Teacher**_____

Name of Medication:	
Dose:	
Route: (by mouth, on skin, in eye, etc.)	
Time(s) to be administered:	
Special Instructions:	
EXPIRATION DATE:	

Date	Time	Signature

Date	Time	Signature

HS 604-MA
Rev. 02/12