Northern Gateway
Public Schools

Medication Administration Record

Student's Name: _____ Age: _____ Grade: _____

Medication: _____

Date Medication Delivered: _____ Quantity: _____

Administration Time: _____
(as per instructions) _____
_____

Parent Signature: _____

Principal Signature: _____

MEDICATION ADMINISTRATION RECORD			
DATE	DOSAGE	TIME ADMINISTERED	SIGNATURE