# REGISTER OF ADMINISTRATION OF MEDICATION

Photo

**Name of School / College: ……..**

**Student Name: ……. DOB: …… Class: ……..**

**To be completed by school authorised staff administering medication.**

| Date | Time | Support / Medication – Dosage and mode of administration | Staff Member administering / supervising administration | Signature |
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Record from / / . to / / . Signed: …….. Date :…….

When this form is complete or the course of medication concludes, please retain this form in the student's school file.