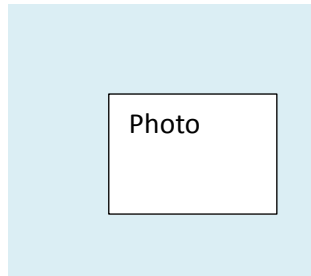




REGISTER OF ADMINISTRATION OF MEDICATION



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

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.