Administration of Medications and/or Treatment
STUDENT'S DAILY RECORD OF MEDICATION
(To be retained in the classroom)

Name of Student: ____

School: ____

Name of Parent/Guardian: ____

Home Address: ____

Home Phone: ____________________ Business Phone: ____________________ Cell: ________________________

Name of Prescribing Physician: ____

Physician's Address and Phone: ____

DATE	AMOUNT/DOSE OF MEDICATION	TIME GIVEN	STAFF SIGNATURE	WITNESS (ADULT)	COMMENTS/OBSERVATIONS IF REACTION IS UNUSUAL

DATE	AMOUNT/DOSE OF MEDICATION	TIME GIVEN	STAFF SIGNATURE	WITNESS (ADULT)	COMMENTS/OBSERVATIONS IF REACTION IS UNUSUAL

Nova Central School District
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Administration of Medications and/or Treatment
SCHOOL MEDICATION RECORD

SCHOOL: ______________________________

(To be Filed in School Office)

Student's Name	Physician's Name & Phone #	Medication	Reason for Medication	Dosage	Time Medication is to be Given	Parent/Guardian	Business/Home/Cell Number	Address