

Please confirm the student's identity.

Student Name:					School:		
Date of Birth: Medication:							
Day Month Year Dosage: Time of Day to be Administered:							
Doctor/Pharmacist Name(s): Designated Employee:							
Date	Time	Given	Designat Employe Signatu	e	Successful (S) Missed (M) Unsuccessful (U) Refused Meds (R)	Additional Comments	