Valley School District

Medication Administration Log

Complete the following information for each medication administered. Use an ink pen for entries. If an error is made, draw a single line through the entry and initial/date. Do not use whiteout.

Student/Child Name:_____Birthdate:_____

School: _____ Teacher:_____

Medication: _____ Dosage: _____

Time(s)/method for administration: _____ ☐ Label matches Authorization

DATE	TIME	DOSAGE GIVEN	QTY/ COUNT	INITIALS	COMMENTS (reason not given, side effects observed, etc.)

Person(s) administering medication:

_____ _____

Name / Signature *Name / Signature*

_____ _____

Name / Signature *Name / Signature*

This record must be kept for a period of eight years.

Medication Administration Log continued for: *(copy this page and add more pages as needed)*

Student/Child Name:_____Birthdate:_____

Medication: _____ Dosage:_____

DATE	TIME	DOSAGE GIVEN	QTY/ COUNT	INITIALS	COMMENTS (reason not given, side effects observed, etc.)