ADVENTIST EDUCATION

Landsdale Gardens Adventist school

ADMINISTRATION OF MEDICINE

Register

Student Name:

Condition:

Name of Medication:

Method of Administration:

Instructions for Administration:

Dosage:
Time:

Parent / Guardian who requests the medication to be administered

Name:_____

Relationship:_____

Signature: _____

OFFICE USE ONLY

DOSAGE	TIME	DATE	NAME OF PERSON ADMINISTRATING MEDICATION	SIGNATURE OF ADMINISTRATOR	SIGNATURE OF WITNESS

Principal's Signature: