Camp Hill Primary School Medication Administration Log

Name of student: _____ Year level: _____

Family Name *(please print)* First Name *(please print)*

Date (Day, month and year)	Time	Name of Medication	Tick When Checked (√)				Comments	Name of staff *(Please print & initial)*
			Right Child	Right Medication	Right Dose	Right Route *(oral/inhaled)*		

Name of Medication:	Prescribed Dose:	Administered by:	Witnessed by: