Camp Hill Primary School Medication Administration Log

Name of student:_____ Year level: _____

Surname *(please print)* **First Name** *(please print)*

			Tick When Checked (√)					
Date	**Time**	**Name Of Medication**	**Right Child**	**Right Medication**	**Right Dose**	**Right Route (Oral/inhaled)**	**Comments**	**Name Of Staff**

Name Of Medication	**Prescribed Dose:**	**Administered by:**	**Witnessed by:**