Prairie Rose School Division

Administration of Prescribed Medication Record

(Please confirm the student identity)

School _____Student Name _____

Birth date _____ Medication_____
Year Month Day

Doctor/Pharmacist Name _____ Dosage_____

Time of day to be administered _____ Designated Employee _____

Date	Time Given	Designated Employee Signature	Successful (S) Missed (M) Unsuccessful (U) Refused Meds (R)	Comments