



# Northeastern Catholic District School Board

Student Record Form for the Administration of Medication	
Name of School	
Name of Student	
Name of Parent	
Parent Contact Information	Home: Work: Mobile:
Name of Medication	
Name of Physician/Nurse Practitioner	
Physician/NP Contact Information	

Names of persons responsible for the administration of medication	School Principal: Teacher(s) in Charge:
Method of Administration and/or Special Instructions	

Dosage	Date	Time	Notes	Signature/Initial of Principal/TIC

Principal Signature: \_\_\_\_\_

Date: \_\_\_\_\_

