Toronto District School Board

# STUDENT LOG OF ADMINISTERED MEDICATION

NAME OF STUDENT: _____ DATE OF BIRTH: _____

SCHOOL: _____ PRINCIPAL: _____

PARENT/GUARDIAN TELEPHONE NUMBER: _____ ALTERNATE NUMBER: _____

**To be completed by teacher or other adult who administered medication:**

| Date and Time | Name of Medication | Dosage of Prescribed Medication (inhaler) | Signature of Person Administering Medication | Parent/Guardian /Caregiver Contacted |
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