Office of the School Nurse

STUDY TRIP MEDICATION ADMINISTRATION LOG

STUDENT'S NAME:_____

TEACHER/GRADE LEVEL: _____

DATE & TIME	MEDICATION/DOSE:	SPECIAL INSTRUCTIONS	SIGNATURE	COMMENTS

This form is a part of the permanent record for students receiving medication during school hours. Fill in the above areas with the date and time the medication given and the signature of the person administering the medication. ***Only DoDEA personnel or the parent of the student is allowed to administer medications.***

_____
School Nurse Signature