Appendix 2
Record of Administration of Prescribed Medication

Name of person: ……..
(Print name)

Date of birth: ……..(dd/mm/yyyy)

Date	Time	Name of Medication	Prescribed Dose	Dose given to child	Administered by: (name).	Witnessed by:	Parent's signature	Any other comments eg. child refused medication
					Sign Print			
					Sign Print			
					Sign Print			
					Sign Print			
					Sign Print			
					Sign Print			

This document must be completed only by the person who administers the medication to the above named individual.