Appendix 3

THE DURHAM DISTRICT SCHOOL BOARD
ADMINISTRATION OF ORAL MEDICATION

CHILD MEDICATION LOG

Name of child/pupil: _____
Name of Parent: _____
Home Address: _____
Home Phone: _____ Business Phone: _____
Name of Prescribing Physician: _____
Office Address and Phone: _____

DATE	***NAME/DOSE OF MEDICATION***	***TIME GIVEN***	***STAFF SIGNATURE***	***COMMENT/ OBSERVATION OR REACTION IF SIGNIFICANT***