GIRRAWEEN PRIMARY SCHOOL
STUDENTS MEDICATION RECORD

NAME OF STUDENT _____
SCHOOL _____ **CLASS** _____

MEDICAL INFORMATION

NAME OF DRUG _____
DOSE TO BE GIVEN _____
TIME TO BE GIVEN _____
DOCTORS NAME _____
DATE OF PARENTAL REQUEST _____/____/____
REPLACEMENT DATE OF DRUG (If appropriate) _____/____/____

COMMENTS _____
_____

Date	Time Given	Signature	Date	Time Given	Signature