Non-Injectable Medication Administration Record

Parent of Guardian, Please Complete the Top Portion of This Form

I request the nurse or designated school staff memeber to give:
Name of Student:_____ Grade:_____ Teacher:_____
Name of Prescribed Medicine:_____ For treatment of:_____
Exact Dosage:_____ Time:_____
Date to Begin:_____ Date to End:_____ Amount of Medication Left:_____
Prescribing Physician:_____ Physicians Phone:_____
Parent/Guardian's Signature:_____ Date:_____
Home Phone:_____ Work Phone:_____ School:_____

Return this form with the properly labeled medication to the school office.

Record of Prescribed Medication Administered

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug.																															
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
April																															
May																															
June																															

Initial: Name of Person Administering Medicine

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Codes: A=Absent
D=Early Dismissal
F=Field Trip
H=Holiday
DC=Discontinued
N=None Available
0=No Show
W=Dose Withheld
"=Weekend