MEDICATION ADMINISTRATION RECORD

TO BE COMPLETED FOR EACH MEDICATION

_____ Assistance with Self-Administration

School Year _______________________

_____ Medication Administration

Name of Student _______________________________________ Date of Birth _________________ Sex ____

Name of School _______________________________________ Grade/Homeroom (or Teacher) _____________________________________

Name and Dosage of Medication _______________________ Frequency __________ Time(s) Given in School ____________________

Directions: Initial with time in box. A complete signature and initials of each person should be included below.

	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																															
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															

INITIAL SIGNATURE INITIAL SIGNATURE

(Of School Personnel or Nurse)

1. __________ ________________________________ 5. __________ ________________________________
2. __________ ________________________________ 6. __________ ________________________________
3. __________ ________________________________ 7. __________ ________________________________
4. __________ ________________________________ 8. __________ ________________________________

CODES: (A) Absent; (E) Early Dismissal; (F) Field Trip; (N) No Medication Available; (0) No Show;
(W) Dosage Withheld; (X) No School (i.e. holiday, weekend, snow day, etc.)

DATE	EXPLANATION (with signature)	DATE	EXPLANATION (with signature)

Adoption date: