Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)

Student Name: ____________________ Gender: M F Date of Birth: __________ Grade: ______ Date of Order: ________

School: ____________________ Order Expires End of School Year or (date): ________

Reason for Medication: ____________________ Order valid for current year including summer school (Check if appropriate): □

Name of Medication: ____________________ Dose: __________ Strength: ________

Time to Give Medication: __________ Route: ________ Frequency of Medication: ________ Date Med. Expires: ________

Possible Side Effects: ____________________ Allergies: ____________________

Special Instructions: ____

☐ Student may carry and self administer medication for asthma or other airway constricting conditions MD Initials

PRINTED PHYSICIAN/PRESCRIBER NAME AND SIGNATURE

PARENT/GUARDIAN SIGNATURE

Medication Administration Record (For School Use Only)

Nurse Reviewed: **Dates Reviewed:**

	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
August																															
September																															
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July																															

Name/Position	Initials	Name/Position	Initials

Nursing assessment has been completed for student self administration

Student may / may not self administer (Circle One)

RN Signature Date

CODES: Chart reason (See H.S. Manual)

X: School Closed FT: Field Trip

A: Absent R: Refused

N: None Available O: Omitted

NS: No Show to HR H: Dose Held

D/C: Med. Discontinued

L/E: Late Arrival/Early Dismissal