

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
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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																																
October																																
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January																																
February																																
March																																
April																																
May																																
June																																
July																																

Name/Position	Initials	Name/Position	Initials	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
Nursing assesment has been completed for student self-administration				D/C: Med. Discontinued
Student may / may not self administer (Circle One)				L/E Late Arrival/Early Dismissal
		RN Signature	Date	