RECORD OF ADMINISTERED PRESCRIBED MEDICATION

School _____

Student Name _____

Birth date _____ (y / m / d)

Medication: _____

Dosage _____ Time to be administered _____

Doctor _____ Phone # _____

Pharmacy _____ Phone # _____

Date	Time Given	Staff Initials	Successful (s) Missed (m) Unsuccessful (u) Refused (r)	Comments (Yes, No, Reason, Details)

Notes:

1. This form is to be completed and initialed each time medication is administered.
2. A separate form is to be completed for each prescribed medication.

Adopted September 1, 2009		