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		