MEDICATION ADMINISTRATION RECORD

Student Name:_____ Grade:_____ School:_____

Medication:_____ Diagnosis/Purpose of Medicine:_____

Instructions for Administering at School (Dose/Time):_____

Possible Side Effects:_____

How Long? _____days/weeks/months/continuous Prescribing Health Care Provider:_____

Date:_____ Physician Signature:_____

I request that the principal or his/her designee administer the medication as directed above. I understand that it is my child's responsibility to report to the office for this service and my responsibility to furnish this medication and inform the school of any changes in my child's health or change in medication. I authorize the release of information between the school and physician pertinent to my child's medication.

Signature of Parent/Guardian:_____ Date:_____Phone:_____

INHALER/EPI PEN EXCEPTION: My child has been in instructed in the proper use of the above mentioned inhaler/epi pen. I request that he/she be permitted to carry the inhaler/epi pen and self-administer the medication.

Signature of Parent/Guardian:_____Date:_____Phone:_____

MEDICATION COUNTS

Date/Time	Expiration Date	On Hand	Received	Returned	Total	Initials

Initials	Signature/Title	Initials	Signature/Title
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DATE	COMMENTS