

**MEDICATION ADMINISTRATION RECORD**

School Year: \_\_\_\_\_ School: \_\_\_\_\_  
 Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 Medication/Procedure: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_  
 From: \_\_\_\_\_ 20 \_\_\_\_\_ To: \_\_\_\_\_ 20 \_\_\_\_\_

See "Prescription & Authorization for Medication Administration" or "Authorization for Administration of Specialized Health Care Procedures."  
 Attach Medication Administration Record to appropriate form for instructions and reference.

	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																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

See comments on back of form.  
 Ab+Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed Ho=Holiday Ft=Field Trip OOM=Out of Medication

<b>Initials</b>	<b>Name</b>	<b>Initials</b>	<b>Name</b>

## Medication

Date Brought to School	Number of Meds Counted	Who Counted
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

## Documentation

Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Int.	Signature	Int.	Signature	Int.	Signature
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____