SCHOOL MEDICATION ADMINISTRATION RECORD

Student: _____ DOB: _____ Grade: _____ School: _____ Year: _____

Teacher Name/Phone _____ School Nurse Name/Phone: _____

Medication: _____ Diagnosis: _____ Dose: _____ Time: _____ Route: _____

Orders Rcvd: _____ ☐Daily Med ☐PRN Med ☐Inhaler Physician Name/Phone: _____

Parent Signature _____ Parent Name (PRINT): _____ Parent phone # _____

	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
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
March																															
April																															
May																															
June																															

Name	Initials	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legend

A Absent
B Begin Med
C Dose Change
D Discontinued
E Early Dismissal
F Field Trip
H Holiday
M Missed Dose
N None Available
R Refill Needed
S Snow Day
W Withheld Med
X No School

Six Rights of Safe Medication Administration

Right Patient
Right Medication
Right Route
Right Time
Right Dosage
Right Documentation