

MEDICATION ADMINISTRATION RECORD 2018-2019
PARENT/GUARDIAN, PLEASE COMPLETE THE TOP OF THIS FORM

Student's Name _____ Birthdate _____ Teacher _____ School _____

Name of Prescribed Medicine _____ For Treatment of _____

Exact Dosage _____ Time to be given _____

****I authorize (Legal Prescriber) _____ to disclose to Webb City R-7 medical information for the purpose of administration of the above mentioned medication at school:**

Parent/Guardian Signature

Date

Home/Cell Number _____

Work Phone Number _____

PLEASE RETURN THIS FORM AND THE PROPERLY LABELED MEDICATION TO SCHOOL OFFICE

**Record of Prescribed Medication Administered
 2018-2019 School Year**

FOR SCHOOL USE ONLY

Student _____
Medication _____
Dose _____
Times _____
RX _____

	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	--	--	--	--	--	--	--	--	--	--	--	--	--	--				--	--						--	--					
Sep	--	--	H					--	--						--	--						--	--	--					--	--	--
Oct						--	--						--	--						--	--				--	--	--				D
Nov			--	--						--	--					--	--					H	H	H	--	--					--
Dec	--	--	--					--	--						--	--						D	--	--	H	H	H	H	H	--	H
Jan	H	H	H	H	--	--						--	--						--	--	--					--	--				
Feb		--	--							--	--				--	--	--	--						--	--				--	--	--
Mar		--	--					D	--	--					--	--	H	H	H	H	H		--	--					--	--	
Apr					--	--						D	--	--					--	--	--						--	--		--	
May				--	--						--	--						--	--			D	--	--	--	--	H	--	--	--	
Jun	--	--						--	--						--	--						--	--					--	--	--	

Initials: Name of person administering medicine _____

Initials: Name of person administering medicine _____

Codes: A = Absent H = Holiday W = Dose Withheld SD = Snow Day
 D = Early Dismissal N = None Available -- = Weekend
 F = Field Trip O = No Show DC = Discontinued SB = See Back