Springfield Catholic Schools

Medication Administration Record

Parent or Guardian please complete the top part of this form

I request the nurse or designated staff member to give:

Name of Student ________________________________ Grade ____ Teacher ____________________

Name of prescribed medication ______________________ For treatment of ____________________

Exact Dosage __________________________ Time to be given _______________________________

Date to begin ___________________________ Date to end _________________________________

Amount of medication/date left with school personnel _______________________________________

Prescribing Physician ______________________ Physician's Phone ____________________________

Parent/Guardian Signature ____ Date__ ___________

Home Phone _________________ Work Phone _________________ Cell Phone _________________

RETURN THIS FORM WITH THE PROPERLY LABELED MEDICATION TO THE SCHOOL NURSE

Record of Prescribed Medication Administered

	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																															
OCT																															
NOV																															
DEC																															
JAN																															
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JUN																															
JUL																															

Initial: Name of Person Administering Medicine

_____ ______________________________
_____ ______________________________
_____ ______________________________
_____ ______________________________

Initial: Name of Person Administering Medicine

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Codes:
- A = Absent
- D = Early Dismissal
- F = Field Trip
- H = Holiday
- DC = Discontinued
- N = None Available
- O = No Show
- W = Dose Withheld
- X = Weekend