Individual Student Medication Record

_____ Controlled Substance

_____ Non-Controlled Substance

Name of Child: _____

Allergies: _____

Name of Drug: _____

Amount of Drug: _____

Time of Administration: _____

Condition for which drug is being administered: _____

_____

Relevant side effects to be observed if any: _____

_____

Length of time during which medication shall be administered:

From: _____ To: _____

_____
Authorized Prescriber ordering medication
Phone # _____

ASA or ASA like substitute requested by parent - no M.D. order

_____
Parent's name Phone #

_____
Received from Date Received

_____
Pharmacy Date to re-order

_____
Prescription # Prescription Date

_____
Received and Checked by Quantity

Date Mo/Dy/Yr	Time Given		Dose Given	Legal Signature of Nurse/Qualified Personnel for Schools Administering Medication	Comments	Amt. of controlled drug remaining
	AM	PM				