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 AM PM	Dose Given	Legal Signature of Nurse/Principal/ Teacher Administering Medication	Comments	Amt. of controlled drug remaining