DOCUMENTATION OF PROCEDURE ADMINISTRATION

Student_____ DOB_____ Grade_____

School_____ Teacher_____

Medication/Procedure_____ Dose_____

From_____20___ To_____ 20___

See "PRESCRIPTION OR OVER THE COUNTER & AUTHORIZATION FOR MEDICATION ADMINISTRATION" or "AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES". Attach this to that appropriate form for instruction and reference.

Date	Time In /Out	Comments	Initials

Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed

Signatures_____ _____ _____

_____ _____ _____ _____