

MEDICATION RECORD ADMINISTRATION

AF6720-B

SCHOOL YEAR _____ SCHOOL _____

STUDENT NAME _____ DOB ___/___/___ GRADE _____ TEACHER _____

MEDICATION / PROCEDURE _____ DOSE _____ TIME _____

FROM: _____ 20 _____ TO: _____ 20 _____

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

	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
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

* See Comments on Back Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed Ho=Holiday Ft=Field Trip OOM=Out of Medication
Ed=Early Dismissal

INITIALS	NAME	INITIALS	NAME

