

## Marshfield R-I Schools Medication Administration Record

Expiration Date: \_\_\_\_\_

Parent Informed: \_\_\_\_\_

***I request the nurse or designated school staff member to give:***

**Name of Student:** \_\_\_\_\_ **Grade/Teacher:** \_\_\_\_\_

Name of Medication: \_\_\_\_\_ For Treatment of: \_\_\_\_\_

Exact Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Return this form with properly labeled medication in its original container.*

	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
<b>Aug</b>																															
<b>Sep</b>																															
<b>Oct</b>																															
<b>Nov</b>																															
<b>Dec</b>																															
<b>Jan</b>																															
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<b>Mar</b>																															
<b>Apr</b>																															
<b>May</b>																															
<b>Jun</b>																															
<b>Jul</b>																															

**Initials:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of Person Administering Medicine:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CODES:**

A = Absent	N = None Available
D = Early Dismissal	O = No Show
F = Field Trip	W = Withheld
H = Holiday	. = Weekend

