MEDICATION ADMINSTRATION PLAN

Parent/Guardian please complete info in box below and sign bottom of form

NAME OF STUDENT_____Date of Birth_____
SCHOOL_____Grade_____
NAME OF LICENSED PRESCRIBER_____
BUSINESS TELEPHONE #_____
EMERGENCY TELEPHONE#_____

PARENT/GUARDIAN NAME_____
HOME TELEPHONE#_____
BUSINESS TELEPHONE#_____
EMERGENCY TELEPHONE#_____

FOOD/DRUG ALLERGIES_____

DIAGNOSIS:_____
(if not a violation of confidentiality)

Name of Medication_____Date ordered_____Duration of order_____
Dosage_____Frequency_____Route of Administration_____Expiration Date of Medication Received_____

Quantity of Medication received by school and date:
Specific directions (times to be given)
Possible side Effects, adverse reactions:
Required storage conditions:
Delegated to (if applicable)
Plan for field Trips:
Plans for teaching self administration, if applicable:
Other persons to be notified of medications administration (with parental permission)
Other medications being taken by the student (if not in violation of confidentiality)
Location where medication administration will occur:_____Health Room_____Other(specify)_____
Plan for monitoring medication, if needed:

School Nurse Signature_____Parent/Guardian Signature_____
Date_____Date_____