FAIS MEDICATION ADMINISTRATION FORM

Student Name	Parent Name	Age	Grade	Teacher

Medication is *(check one)* ☐ **over the counter** ☐ **prescription**

All medications must be in the original packaging. For prescriptions you should request an extra labeled container from your pharmacist if you need to keep the original one.

Name of doctor *(Rx only)* _____ Doctor phone _____

Name of medication and strength _____

Dosage _____ Time to administer _____AM _____PM

Reason for medication _____

Possible side effects / allergic reactions _____

Starting date _____ Ending date _____

Parent comment / instructions _____

I hereby request that the authorized FAIS staff administer the above described medication. I also certify that I have read and understood all instructions and warnings about this medication.

Parent / Guardian signature _____ Date_____

For Staff Use ONLY

Amount received (date/initials) _____ Amount returned (date/initials) _____

	Date	Time	Dosage	Initials		Date	Time	Dosage	Initials
1					8				
2					9				
3					10				
4					11				
5					12				
6					13				
7					14				

Staff initial identification (initials / printed name)

Please PRINT, SIGN and return or email to info@faispdx.org.

FAIS MEDICATION ADMINISTRATION FORM

Student Name	Parent Name	Age	Grade	Teacher

Name of medication and strength _____

Dosage _____ Time to administer _____AM _____PM

For staff use ONLY

	Date	Time	Dosage	Initials		Date	Time	Dosage	Initials
1					19				
2					20				
3					21				
4					22				
5					23				
6					24				
7					25				
8					26				
9					27				
10					28				
11					29				
12					30				
13					31				
14					32				
15					33				
16					34				
17					35				
18					36				

Staff initial identification (initials / printed name)
