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_____   _____   _____

_____   _____   _____   _____

7/2022