

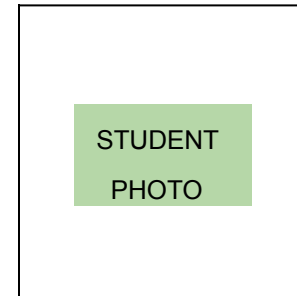
STUDENT NAME: _____ DATE OF BIRTH: _____

SCHOOL: _____ TEACHER/HOMEROOM: _____ GRADE: _____

NAME OF MEDICATION: _____ DOSE PRESCRIBED: _____

ROUTE GIVEN: _____ TIME GIVEN AT SCHOOL: _____ ORDER EXPIRES _____

SPECIAL INSTRUCTIONS: _____



Directions: Complete a new form for each medication given. Initial at the time of administration. On the back of this sheet provide a complete signature with initials of the person administering the medication as well as the signature and initials of the person witnessing. Medication count and comments also on the back.

	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
JULY																															
Witness																															
AUGUST																															
Witness																															
SEPTEMBER																															
Witness																															
OCTOBER																															
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