

STUDENT NAME: _____

MEDICATION SIDE EFFECTS OR SPECIAL INSTRUCTIONS: _____

DATE	MEDICATION	QUANTITY RECEIVED	QUANTITY RETURNED	PHARMACY	PRESCRIPTION #	INITIALS

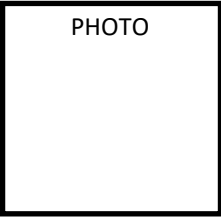
DATE	WEEKLY COUNT	INITIALS
	1	
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	35	

PROGRESS NOTES/ COMMUNICATIONS

- CODE:**
 A=ABSENT
 NM=NO MEDICINE
 R=REFUSED
 D/C=DISCONTINUED
 H=HOLIDAY
 W=DOSE WITHHELD
 NS=NO SHOW
 SD=SNOW DAY
 IR=INDOOR RECESS
 FT=FIELD TRIP

MUSTANG PUBLIC SCHOOLS 2019-2020

MEDICATION ADMINISTRATION RECORD



NAME: _____ GRADE: _____ TEACHER: _____ DATE OF BIRTH: _____ MEDICATION TIME: _____ EXACT DOSAGE: _____

AGE: _____ MEDICATION NAME: _____ START DATE: _____ END DATE: _____ PURPOSE: _____ EXPIRATION DATE: _____

PRESCRIBING PHYSICIAN: _____ PHYSICIAN PHONE: _____ MEDICATION ALLERGY: _____

Parent/Guardian Signature _____ Date: _____ Phone Number: _____

I have received, read and understand the Mustang Public Schools medication policy. I give permission for the Mustang Public School staff to administer medication according to the directions. I give Permission for School Nurse to contact the Physician regarding the diagnosis related to the medication and for clarification of medications orders.

	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
AUG			\	\						\	\						\	\						\	\						\
SEP	\	H					\	\				PD	PD	\	\						\	\						\	\		
OCT					\	\						\	\			SB	SB	SB	\	\						\	\				
NOV		\	\						\	\						\	\						\	\	H	H	H	H	H	\	\
DEC	\						\	\						\	\						\	\	H	H	H	H	H	\	\	H	H
JAN	H	H	H	\	\						\	\						\	\	H					\	\					
FEB	\	\						\	\						\	\	PD						\	\					\	\	\
MAR	\						\	\					SB		\	\	SB	SB	SB	SB	SB	\	\					\	\		
APR				\	\						\	\						\	\						\	\					\
MAY		\	\						\	\						\	\						\	\						\	\
JUN	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

INITIAL PERSON ADMINISTERING MEDICINE INITIAL PERSON ADMINISTERING MEDICINE INITIAL PERSON ADMINISTERING MEDICINE

