

Student Name: _____ Time: _____ Routine or PRN (circle)
 Allergies: _____ Physician: _____ School Yr: _____
 Medication: _____ Dose: _____ Route: _____
 Directions/Special Concerns/Side effects _____

If PRN, as needed for: _____
 Medications administered have been reviewed for possible side effects and interactions by: _____

Initial Date Medication Started at School: _____ Date Stopped: _____	
Changes:	Date: _____ Dose: _____ Time: _____
Changes:	Date: _____ Dose: _____ Time: _____
Changes:	Date: _____ Dose: _____ Time: _____
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Abbreviations: A= Absent X= No School H= Bottle Home NMA= No Med Available
 R=Refused Initialed & Circled = Did Not Take

Initial	Signature	Initial	Signature