Medication Administration Plan

Last Name ______________________________ First Name __________________________

Date of Birth _______________ Grade _______

Parent 1 _________________________________ Relationship _________________________

Home Phone __________________________ Cell phone___________________________

Parent 2 _____________________________________ Relationship _____________________

Home Phone ___________________________ Cell Phone ___________________________

Food/Drug Allergies ____

Diagnoses: ____

Medication name ____

Name of Licensed prescriber____

Date Ordered_____________________ Duration of Order______________________

Dosage__________ Frequency_____________ Route of Administration__________________

Exp. Date of Medication_____________ Quantity of Medication received _________________

Specific Directions, e.g. times to be given____

Possible side effects, Adverse reactions:____

Delegated to ____

Plan for field trips:____

Other persons to be notified of med admin (with parental permission)__________________

Other medications being taken by the student______________________________________

Location where med admin will occur: Health Office field trip

Plan for monitoring medication, if needed:____

School Nurse Signature _____________________________________ Date _____________

Parent/Guardian Signature ____________________________________ Date ____________

(Medication order and parent/guardian authorization may be attached to this form.)