NEW PRAIRIE UNITED SCHOOL CORPORATION HEALTH SERVICES

Medication Form/ Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)

Student Name: _____ Date of Birth: _____ Grade: _____ Date of Order: _____

School: _____ Order Expires End of School Year ***or*** (date): _____

Name of Medication: _____ Dose: _____ Strength: _____

Time to Give Medication: _____ Route: _____ Frequency of Medication: _____ Date Med. Expires: _____

Possible Side Effects: _____ Allergies: _____

Special Instructions: _____

☐ Student may carry and self administer medication for asthma or other airway constricting conditions. MD Initials: _____

/

PRINTED PHYSICIAN/PRESCRIBER NAME AND SIGNATURE **PARENT / GUARDIAN SIGNATURE**

Medication Administration Record (For School Use Only)

	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																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															
Jul																															

Name/Position	Initials	Name/Position	Initials

Codes: Chart reason

X: School Closed
A: Absent
N: None Available
NS: No Show to HR
D/C: Med. Discontinued
L/E Late Arrival/Early Dismissal
FT: Field trip
R: Refused
O: Omitted
H: Dose Held

Notes

Medication Count

Date	Count	Date	Count