Name _____ School _____ School Year _____ Grade _____

Medication: Dosage, times, route of administration, start and end date.

	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																															
SEPT																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															

Signature of Person Administering	Initials	Date

Signature of Person Administering	Initials	Date

Use one sheet per medication/procedure.
Write time, cross off, and initial.
Sign and date at bottom only once to identify initials.
Include completed form in health record.
Enter additional comments on back.

A = Absent
X = No School
O = Not given - comment on back

Date	# Rec.	Initials	Date	# Rec.	Initials	Date	# Rec.	Initials

Approved: 1-11-10

Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	
Date:	