BAKERSFIELD CITY SCHOOL DISTRICT
SCHOOL HEALTH AND WELLNESS

MEDICATION ADMINISTRATION RECORD

This form MUST be renewed whenever the prescription changes. Write in BLUE INK ONLY. Original signatures only. NO WHITE OUT is to be used on this form.

Student Name: ______________________________ Health Care Provider: ______________________________

SID#: ______________ DOB: ______________ Health Condition/Diagnosis: ______________________________

School: ______________ Teacher: ______________ Medication/Treatment ______________________________

Name Dosage Time to be Given

MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY		
Date:			**Date:**			**Date:**			**Date:**			**Date:**		
Time	Code/Comments	Initials	Time	Code/Comments	Initials	Time	Code/Comments	Initials	Time	Code/Comments	Initials	Time	Code/Comments	Initials
Date:			Date:			Date:			Date:			Date:		
Time	Code/Comments	Initials	Time	Code/Comments	Initials	Time	Code/Comments	Initials	Time	Code/Comments	Initials	Time	Code/Comments	Initials
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CODE LEGEND		COMMENT EXAMPLES
A = Absent	**N** = No medication available	• vomited medication
G = Medication Given	**R** = Refused - parent notified	• left school before medication time
H = Holiday	**M** = Missed - parent notified	

I certify that all information included on this document is true, accurate and complete.
I certify that I have been trained by the Credentialed School Nurse to perform these specialized healthcare treatment services for this student.

Date	Printed Name	Job Title	Signature	Initials

I certify that all information included on this document is true, accurate and complete.
I certify that I have trained these Staff to perform these specialized healthcare treatment services for this student.

Date	Print School Site Nurse Name	Signature	Initials

Student Name: _____ Date of Birth: _____

DIRECTIONS

(*ALL* recording must be done in BLUE INK ONLY. ORIGINAL signatures only. NO WHITE OUT is to be used on this form.)

Upon delivery of medication by parent/guardian to the school:

1. Validate completion of the authorization forms from parent **AND** health care provider.
2. Validate the health care provider's instructions from the authorization form.
3. Complete identifying information on top section of side 1.
   Use only one log per student/per medication.
4. Using the medication counting tray, count the medication in the presence of the parent/guardian.
5. Complete the following box:

MEDICATION RECEIVED

Date received: _____

Name of Medication: _____

Type of Medication: ¨Oral ¨Inhaler ¨Topical ¨Injectable ¨Other

Dosage: _____ Schedule: _____

Amount Received: _____ + _____ = ___ Est. # of days supply to last: _____
(on hand)

Staff Signature: _____

Parent/Guardian Signature: _____

Date medication originally received: _____

Medication transferred to _____(month)_____(amount)

Signature: _____ Date: _____

Witness: _____ Date: _____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

No medications given in _____Signature_____Date:_____

MEDICATION RETURNED TO PARENT

Amount returned: _____ _____ Date: _____

Type of Medication: ¨Oral ¨Inhaler ¨Topical ¨Injectable ¨Other

Parent/Guardian Signature: _____

Staff Signature: _____

Date disposed of by Staff: _____

Signature: _____ Witness: _____

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Date	Printed Name	Job Title	Signature	Initials

I certify that all information included on this document is true, accurate and complete.
I certify that I have trained these Staff to perform these specialized healthcare treatment services for this student.

Date	Print School Site Nurse Name	Signature	Initials