

HCPSS SCHOOL HEALTH SERVICES

IFAS #39513035 Form

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

Student Name: _____ Gender: M F Date of Birth: _____ Grade: _____ Date of Order: _____
 School: _____ Order Expires End of School Year or (date): _____
 Reason for Medication: _____ Order valid for current year including summer school (Check if appropriate)
 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)

Nurse Reviewed:	Dates Reviewed:																															
	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	
August																																
September																																
October																																
November																																
December																																
January																																
February																																
March																																
April																																
May																																
June																																
July																																

Name/Position	Initials	Name/Position	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CODES: Chart reason (See H.S. Manual)

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

Nursing assesment has been completed for student self-administration
 Student may / may not self administer (Circle One) _____
 _____ RN Signature _____ Date _____