MEDICATION ADMINISTRATION FORM

(Please Print)

Student Name_____
Last

_____
First Middle

Birthdate_____ Age_____

School_____ Grade_____

Date_____, 19_____

This is to be completed at the beginning of each school year for students on long-term medication. If any change in medication or dosage takes place, a new form must be completed.

USE ONE FORM FOR EACH MEDICATION

DIAGNOSIS:

ICD-9 CODE:

NAME OF MEDICATION:

DOSAGE:

TIME OF ADMINISTRATION:

METHOD OF ADMINISTRATION:

COMMENTS, e.g., Side-effects, reactions, and/or other instructions:

NOTE: The medication will be administered by designated employee(s) of Kanawha County Schools. This may be the principal, teacher, classroom aide, secretary, nurse or other.

Physician's Name_____
(Please Print)

Physician's Signature_____

Date_____ Telephone Number_____

Parent's Signature _____
Parental Signature Approving the Administration of the Medication

Date_____ Telephone Number_____

ESMa1
8/96

Cross Lanes Christian School
5330 Floradale Drive
Cross Lanes, WV 25313