ROBINSON I.S.D.
MEDICATION ADMINISTRATION FORM
Prescription and/or Over-the-counter
ONE MEDICATION PER PAGE

Student Name: _____ *Grade :* _____ *Teacher:* _____ *D. O. B. :* _____

Medication Name: _____ *Dose:* _____ *Times to be given:* _____

Reason for medication: _____

Prescription # _____ *Pharmacy Name* _____ *Pharmacy Phone Number* _____

Prescribing MD _____ *Prescribing MD Phone Number* _____

Dates to be given: _____ *to* _____ ***An adult MUST PICK UP the medication at the end of the year?*** *Initials* _____

If medications is a partial dose (1/2 tablet), please make sure ALL medication is cut in half before giving to school*

Parent/Guardian Signature: _____ *Phone:* _____ *Date:* _____

ABOVE SECTION FOR PARENTS TO COMPLETE. BOTTOM SECTION FOR SCHOOL STAFF ONLY.

Number of Pills Added: _____ Date: _____Initials _____ Number of Pills Added: _____ Date: _____Initials ____

Number of Pills Added: _____ Date: _____Initials _____ Number of Pills Added: _____ Date: _____Initials ____

Number of Pills Added: _____ Date: _____Initials _____ Number of Pills Added: _____ Date: _____Initials ____

ADMINISTRATION DATES AND TIMES:

Date: _____ Time: _____ Administered By: _____

Date: _____ Time: _____ Administered By: _____

Date: _____ Time: _____ Administered By: _____

Date: _____ Time: _____ Administered By: _____

Date: _____ Time: _____ Administered By: _____

Date: _____ Time: _____ Administered By: _____

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