Student Name_______________________________________ Grade_________ Teacher__________________________________

Medication____ Dose_________ Time Scheduled_____________ Route__________

Physician____ Phone#______________________ School RN#_________________

Date	Time	Initial	Date	Time	Initial	Date	Time	Initial	Date	Time	Initial

Student Name_____ Grade_____ Teacher_____

Medication_____ Dose_____ Time Scheduled_____ Route_____

Physician_____ Phone#_____ School RN#_____

Date	Time	Initial	Date	Time	Initial	Date	Time	Initial	Date	Time	Initial

Name and title of person administrating medications:

_____	_____	_____
Print name	Signature	Initals
_____	_____	_____
Print name	Signature	Initals
_____	_____	_____
Print name	Signature	Initals
_____	_____	_____
Print name	Signature	Initals
_____	_____	_____
Print name	Signature	Initals
_____	_____	_____
Print name	Signature	Initals
_____	_____	_____
Print name	Signature	Initals

End of the year Disposal of Medications

Medications will be disposed of at the end of the year if parent/guardian do not pick up by the designated date. The disposal will be witnessed by another school employee and then verified by signing below.

Number of pills destroyed:_____

_____	_____	_____
Print name	Signature	Date
_____	_____	_____
Print name	Signature	Date