Howard County Public School System

39513035

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 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

Nursing assessment has been completed for student self administration ______

Student may/may not self administer (circle one) RN signature Date

CODES: Chart reason

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

39513035 Reverse

HOWARD COUNTY PUBLIC SCHOOL SYSTEM
MEDICATION RECEIVING/DISPOSING RECORD

Student Name: ______________________ **School:** ______________ **Grade:** __________

Date	Medication Name/Dose Equipment	Current Count	Number Received	# Wasted, Returned, or Destroyed	New Total	Parent Signature	Health Room Staff Signature	Comments