

# 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 \_\_\_\_\_