Sample Medication Administration Plan

Name of student_________________________________ Date of Birth__________

School____Grade_________

Parent/guardian name_______________________________________

Home telephone___________________________________ Business telephone_________________________________

Emergency telephone_______________________________ Cell Phone _______________________________________

Food/drug Allergies____

Diagnoses:____
(if not a violation of confidentiality)

Name of Medication:____

Name of licensed prescriber____

Date Ordered___________________________ Duration of Order_____________

Dosage______________ Frequency_________________ Route of Administration____________________________ Expiration Date of Medications

Received____________

Specific Directions, e.g., times to be given:____

Possible Side Effects, Adverse
Reactions:____

Quantity of Medication Received by School and
Date:____

Delegated to (if applicable): ____

Back-up Plans (if delegatee
unavailable):____

Plan for Field Trips:____

Plans for teaching self administration, if
applicable:____

Other persons to be notified of medication administration (with parental
permission):____

Other medications being taken by the student (if not in violation of
confidentiality):____

Location where medication administration will occur: _____Health Room _____Other
(specify)____

Plan for monitoring medication, if
needed:____

School Nurse Signature________________________________ Parent/Guardian Signature_________________________

Date_________________ Date _______________

Student's Signature, if appropriate____________________

Date _______________

(Medication order and parent/guardian authorization may be attached to this form.)