MEDICATION ADMINISTRATION RECORD

Attention physician/licensed prescribers: If you are faxing this sheet please send to:

East Butler Public Schools Attention: School Nurse Phone 402-545-2081 Fax 402-545-2023

Parent and Physician Request for Administration of Medication at School

_____ is under my care and should receive
(Name)

_____ _____ _____
(Medication) (Dose) (Route) (Frequency)

Adverse Reactions which should be reported to physician: _____

Special Instructions for administration: _____
Known Allergies: _____

Date: _____ **Physician/ Licensed prescriber signature** _____

Parent/ Guardian Signature _____

***SHOULD A CHANGE IN ANY OF THE ABOVE INFORMATION OCCUR, A REVISED WRITTEN PHYSICIAN STATEMENT MUST BE SUBMITTED. MEDICATION MUST BE BROUGHT TO SCHOOL BY AN ADULT, IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST OR PRESCRIBER

****** (below this line is for school use only) ******

Date	Medication/Dose	Number of Tablets	Parent Signature	Nurse Signature

ALL MEDICATIONS MUST BE PICKED UP BY THE END OF THE SCHOOL YEAR OR IT WILL BE DISCARDED

Medication returned: _____ _____ _____ _____
(Date) (# of tabs) (Received by) (Nurse Signature)