

# MEDICATION ADMINISTRATION RECORD

JP II CATHOLIC SCHOOLS

Grad Yr: \_\_\_\_\_

**Medication Procedure**

**Dose**

**Time**

**Special Instructions**

	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																																

\*See comments on Back AB=Absent Re=Refused NS=No Show Ho=Holiday

INITIALS	NAME	INITIALS	NAME

# MEDICATION ADMINISTRATION RECORD

JPII CATHOLIC SCHOOLS

Grad Yr: \_\_\_\_\_

This form needs to be completed when it is determined by a physician that medication must be taken during the school hours. Also, it is necessary to fill this out for your child to receive any form of Acetaminophen or Ibuprofen. Please send medication to school labeled with the student's name.

## PRESCRIPTION MEDICATIONS

\_\_\_\_\_  
Medication

\_\_\_\_\_  
Dose

\_\_\_\_\_  
Route

\_\_\_\_\_  
Time / Frequency

\_\_\_\_\_  
Continue Until

\_\_\_\_\_  
Special Instructions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Major Side Effects

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Amount of Medication Received by School

\_\_\_\_\_  
Received by

\_\_\_\_\_  
Expiration Date

## NON-PRESCRIPTION MEDICATIONS

\_\_\_\_\_  
Medication

\_\_\_\_\_  
Dose

\_\_\_\_\_  
Route

\_\_\_\_\_  
Time / Frequency

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Amount of Medication Received by School

\_\_\_\_\_  
Received by

\_\_\_\_\_  
Expiration Date

### SHANLEY / SACRED HEART PARENTS ONLY

**My child may take SHANLEY/SACRED HEART supply of Acetaminophen (Tylenol) or Ibuprofen as needed (please check below).**

1 Tablet    2 Tablets    1 Tablet    2 Tablets

**500 MG Acetaminophen   200 MG Ibuprofen**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

## ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_

## DISCLAIMER

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes or there is a change or cancellation of this medication.

In consideration of this authorization, given at our request, the undersigned agrees to indemnify, defend, and save harmless St. John Paul II Catholic Schools, the individual members, thereof and any officials or employees of St. John Paul II Catholic Schools involved in the administration of medication to the above named student from any claims or liability or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date