Code No. 507.2E1

Long Term Medication Administration Record <Current Year>

Student Name _____ Grade_____

Medication Name & Strength _____

Amount & Time to be given _____

_____

Doctor	
Person giving medications	
name	initials

Doctor sign	
Parent sign	
Label	
By Mouth	
Inhaled	
Other	

AB your initials, as written above **X** no school **A** student absent **O** not given, write comments below **R** refused ⁄ two doses given

Date	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
AUG																															
SEP																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															

Comments: _____

_____

_____