LOWER CAPE MAY REGIONAL SCHOOL DISTRICT – Medication Administration Record

PRESCRIPTION Medication Form

I request that: _____ Grade _____ ID# _____

(Student Name)

Receives the following medication: _____

Prescribed by _____ for _____

(doctor) (reason/illness)

This medication is to be given (daily/as needed/at lunchtime/etc) _____

Parent/Guardian Signature_____ Date_____

- Absolutely NO medications will be given without WRITTEN parent/guardian PERMISSION.
- **Prescription medications MUST have a WRITTEN prescription from the doctor including medication name, dose, and time to be given.**
- Medications MUST be in the labeled prescription bottle from pharmacy.
- Medications MUST be kept in nurse's office.
- Students must have appropriate paperwork to self-carry inhalers (asthma action plan) or epi pens (epi pen form).
- Use ONE FORM for each prescription medication.

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PRESCRIPTION Medication Form (School Year _____)

Student: _____ Prescription Medication: _____

	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Nurse's Signature: _____ _____

_____ _____

_____ _____

Codes: A/Absent N/None Available D/Dismissed Early