MEDICATION ADMINISTRATION RECORD

Attention physician/licensed prescribers: If you are faxing this sheet please send to Riverside School District, Attn: Stephanie Murdock RN, CSN @ 724-758-7519 for Kindergarten and grades 9-12 OR
Attn: Amber Gebhart RN, CSN @ 724-758-0919 for grades 1-8

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)