

TRINITY SCHOOL MEDICATION AUTHORIZATION -- PHYSICIAN ORDER School Year _____

Parent Signature _____ I authorize school personnel to administer this medication to my child.

Student Name _____		DOB _____	Grade _____
Allergies _____			
Medication _____		Date to begin _____	End date _____
Reason for Medication _____		Dose _____	Route _____
Time to be given _____		Side Effects _____	
If prn for what symptoms _____		Frequency _____	
<ul style="list-style-type: none"> • Student may carry and self administer this medication? ___ NO ___ YES ___ Supervised ___ Unsupervised 			
Physician _____		Phone# _____	
PRINT NAME			
Signature _____		Date _____	

MEDICATION ADMINISTRATION RECORD (School Use Only)

	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
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
June																															

Name/position _____	Initials _____	Name/position _____	Initials _____
_____	_____	_____	_____
_____	_____	_____	_____

CODES:
X = School Closed O = Omitted FT = Field Trip
A = Absent ED = Early Dismissal D/C = Discontinued
N = None available R = Refused NS = No Show