Nursing Services Record – Medication Administration/Management

Student Name: ____________________ **DOB:** __________ **ID:**______________
Month of Service/Year: ______________ **Service Duration (IEP Dates):** _______________ **Group:** 1
School: ____________________________ **Grade:** _________

Medication Name: _______________________________ **Medication Route/Dosage:** ________________________________
Time Administered: _______________ _______________ _______________

Date	Start Time	Total Time	Initials	Start Time	Total Time	Initials	Start Time	Total Time	Initials
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
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25									
26									
27									
28									
29									
30									
31									

Monthly Medication Summary (LSN Review)
Student Tolerated Medication: Yes ☐ No ☐ Changed Dose/Frequency: Yes ☐ No ☐ Continue Plan: Yes ☐ No ☐
Side Effect Noted (if yes, comment): Yes ☐ No ☐ Total Time for LSN Review: _________________
(**Enter the code "mgmt." behind your initials in the above grid for medication management**)

Comments

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Codes: X = no school; AB = absent; R = student refused; NONE = medication not at school; circle = indicates that you forgot to give med/treatment *Write date on back of this form and what you did about it (i.e. called parent, notified nurse, etc.). Sign your entry. You must fill out an incident/unsafe situation report and give to the school nurse to forward to the proper authorities. LSN*.

Health Associate/Paraprofessional:
Initials _______________ Signature ____ Date ____________________
Initials _______________ Signature ____ Date ____________________

Licensed School Nurse:
Initials _______________ Signature ____ Date ____________________

The original should be placed in the building file for all students.
For Third Party Billing students, send a copy to Donniel Robinson at the DAO monthly.