THE SCHOOL BOARD OF WAKULLA COUNTY, FLORIDA and FLORIDA DEPARTMENT OF HEALTH IN WAKULLA COUNTY
SCHOOL HEALTH SERVICES

MEDICATION/TREATMENT ADMINISTRATION LOG

Student Name (Print) | Sex | DOB | Contact Name | Contact Phone No.

School | Teacher | Grade | School Year | Original Authorization Date

Reviewed by RN Name (Print)_____RN Signature_____Date _____

Diagnosis forthis Medication/Treatment_____Name of Treatment _____

Name of Medication_____Medication Expiration Date _____
Brand Generic Strength

Allergies _____

Route: (Check one) ☐ Oral ☐ Topical ☐ Subcutaneous ☐ I.M. ☐ Inhaled ☐ Other (describe) _____

Amount (i.e.: # of tablets or teaspoons)	Time for administration in school (if more than once, use separate log)	Frequency (for PRN)	Duration

Codes			
/	No School	D	Early Dismissal
A	Absent	X	Dose Not Taken (Explain on other side)
		S	Stopped Medication (Explain on other side)
N	None Available	O	Other (Explain on other side)
#	Medication Received-Quantity Documented on Reverse Side of Form		

ENTER TIME AND INITIALS FOR EACH DOSE GIVEN

	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																															
Jul																															

Employee Administering Medication/Treatment

Name (Print) Signature Initials | Name (Print) Signature Initials | Name (Print) Signature Initials

Name (Print) Signature Initials | Name (Print) Signature Initials | Name (Print) Signature Initials

RET: Master, 7Y GW, GS7 158
Dupl., OSA

MEDICATION/TREATMENT ADMINISTRATION LOG

Documentation of Prescription Receipt/Pick-up

Student Name (Print) _____ DOB _____ School _____

Prescription Pickup or Delivery Receipt for _____ (Name of Medication and Dosage)

	Quantity of Medication				
Date of Transport	# Received	# Returned	# On Hand	Total	Signatures
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/

Prescription Pickup or Delivery Receipt for _____ (Name of Medication and Dosage)

	Monthly Medicine Check			
Month	Date	# per Log	# on Hand	Signatures
AUG				/
SEPT				/
OCT				/
NOV				/
DEC				/
JAN				/
FEB				/
MAR				/
APR				/
MAY				/
JUN				/
JUL				/
				/
				/
				/
				/

X	Dose not taken
Date	Explain
S	Stopped Medication
Date	Explain

O	Other
Date	Explain

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