Dorado Academy

MEDICATION ADMINISTRATION FORM

I hereby authorize the School Nurse to administer my child's prescribed medication.

Student's name: _____ Grade: _____

Child's doctor: _____

Specialization: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian's signature: _____ Date: _____

MEDICATION	DOSAGE	FREQUENCY/TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ADMINISTRATION LOG **FOR OFFICIAL USE ONLY**

Date	Time	Medication	Dosage	Route	Initials

Revised September 2018