West Allis West Milwaukee School District – 1205 South 70th Street, West Allis, WI 53214 – 414-604-3000

Medication Administration Record

School Name: ____

Student Name: ________________________________ Date of Birth: ____________________

Medication: _________________________________ Dosage: ______________________

Time(s): ____________________________________ Route: ______________________

Physician/Phone: __________________________ Pharmacy/Phone: ________________________

Teachers Name: _______________________________ Extension: ____________________

- Document medication with time and initials
- Put full signature and initials on reverse side
- Medication count on reverse side

Week	M	T	W	TH	F

Week	M	T	W	TH	F

Key: A=Absent X=No School OOM=Out of Medication FT=Field Trip O=Not Given

Record explanation in comments on reverse side

Full Signature, Initials, and Title must be completed by everyone who administers medication to this student.

Signature: _____ Initials: _____ Title: _____

Signature: _____ Initials: _____ Title: _____

Signature: _____ Initials: _____ Title: _____

Signature: _____ Initials: _____ Title: _____

Signature: _____ Initials: _____ Title: _____

Signature: _____ Initials: _____ Title: _____

Medication Counts: To be completed each time a new supply of medication is received.

July			August			September			October			November			December		
D	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**

January			February			March			April			May			June		
D	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**	**D**	**#**	**In**

D=Date #=Quantity of Medication IN=Initials

Comments: _____

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School Board Medication Policy: 453.4

Note: This form is to be kept in the student's health file for one year from completion. For questions, call the Nursing Department at 414-604-4000 x.1107