FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

Written Record for Dispensing Oral Medication: School Year _____

Student: _____   DOB: _____   Teacher: _____

Medication/dosage supplied: _____/_____ Amount Administered: _____

Administration Time: _____   Start Date: _____End Date: _____

Special Administration Instructions: _____

Codes: X: No School   N: None Avail   O: No Show   F: Field Trip   D: Early Dismissal   A: Absent   W: Dose Withheld   L: Late Arrival

Date	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																															

FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

Written Record for Dispensing Oral Medication: School Year _____

Initial/Signature: _____/_____ Initial/Signature: _____/_____
Initial/Signature: _____/_____ Initial/Signature: _____/_____
Initial/Signature: _____/_____ Initial/Signature: _____ /_____

Medication Received: Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____
                        Date _____ Amount/Initial _____/_____

Medication Picked Up: Date _____ Signature/Staff Initials _____/_____
                          Date _____ Signature/Staff Initials _____/_____
                          Date _____ Signature/Staff Initials _____/_____

Medication Discarded: Date _____ Staff Initials _____

Nurse Review: Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____
                  Date _____ Reason _____ Signature _____