Medication Administration Form

Student's name: …….……. Class: ……

Name of medication:

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Dose per each administration: …….……

Time the medication to be administered: ……..

For dates: From: ……/……../..... to: ……/……../..... .....

Any other information we should be aware of in relation to the student's health or the medication (such as possible side effects).

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Parent/guardian name: …….……

Parent/guardian signature: …….……

FCPS staff member signature: ……..……...