MOLALLA RIVER SCHOOL DISTRICT

MEDICATION ADMINISTRATION RECORD

Student Name:		DOB:	
Medication Name:		Dose:	
Route: ☐ Oral ☐ Topical (skin, eyes, ears) ☐ Inhaled (nose, mouth) ☐ Other ☐ Associated Plan :		Specific time/frequency to be administered	

INVENTORY

[Counts must be witnessed for anti-seizure medications, psychotropic medications, sedatives, narcotics or any controlled substances]

Count in:		Date:		Signature:		Witness:	
Count out:		Date:		Signature:		Witness:	
Count in:		Date:		Signature:		Witness:	
Count out:		Date:		Signature:		Witness:	

Trained Medication Personnel or Licensed Personnel:	Name:		Signature:		Initials:	
	Name:		Signature:		Initials:	
	Name:		Signature:		Initials	
	Name:		Signature:			
	Name:		Signature:			

LOG OF MEDICATION ADMINISTRATION

Date:	Time:	Initials:	Remarks:

Student Name:		DOB:	

LOG OF MEDICATION ADMINISTRATION

Date:	Time:	Initials:	Remarks:

Each dose must be logged; any errors should be recorded on a *Medication Incident Report.*

Reviewed by RN:		Date:	