Duval County Public Schools andExpiration Date According to Prescription Label_____Florida Department of Health in Duval CountySchool Health Services

Medication Administration Record School Year 2023-2024

Student:DOB: School:Allergies:				Teacher:				
Parent/Guardian Name:Parent/Guardian Phone:Pose:Dose:								
	by mouth:			other		Specific Time:	AM	PM
Reason to be given: Special instructions:								
Date	Prescription Number (or Note OTC)	Medication Expiration Date	# Received	Pills are whole(W) or half (H) (Circle one)	L i q u i d	Parent Signature	Staff Signature	

Student:

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Comments:	

Student:	DOB:	Medication:	
Student		_	

Dose:_____Time: _____

Medication Sign Out For School Activities

Date OUT	Medication Count- OUT	Staff Signature OUT	Health Room Staff Signature OUT	Date Medication Returned	Medication Count- Returned	Staff Signature IN	Health Room Staff Signature IN