



School Health Program  
Field Trip Medication Clinical Service Notes

(Form Date: 7/9/09)

Student's Name:		Date of Birth:
School:		Grade:
Medication:	Dosage & Route:	Date/Time/Initials of Person Transcribing Order:
Time:	Allergies:	

Starting Medication Count = _____  (Controlled substances must be counted by two school employees. The person who will be responsible for the medications on the field trip should be one of the persons involved in the count. The school nurse should also be involved in the count.)	Date: _____  Initials of Counter: _____  Initials of Witness: _____
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Date	Time Medication Given	Medication Code*	Signature of Person Giving Medication

1. Starting Count = _____ 2. Number Given = _____ 3. Ending Count = _____ 4. (Starting Count) – (Number Given) = _____  The totals for #3 should equal #4. If there is a discrepancy, the reason for the discrepancy must be explained on the back of this form. The school principal and the school nurse must be notified.	Date: _____  Initials of Counter: _____  Initials of Witness: _____
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Print Name	Signature (with credentials)	Initials

\*Medication codes explained on back.

