Prince William County Public Schools
Medication Administration Log
For Extended Day/Overnight Field Trips

Student's Name: ___________________________________ School: _______________________

Grade: ________________ Teacher/Homeroom: ______________________________________

Reason for Medication/Diagnosis: ____

Allergies: ____

Medication: ____

Dosage: ______ Amount: _____________ Route: ________ Time(s) to be Given:__________
(mg) (# of pills, tsp., cc, drops) (by mouth, in ear, etc.)

Date Received (original Rx)______ #/Amt. of Pills/Capsules/Liquid____ Signature__________

Date Returned (end of year/use)____ #/Amt. of Pills/Capsules/Liquid____ Signature_________

Date (Use new line for each date)	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Signature

Return form to school clinic after trip.