DOCUMENTATION OF PROCEDURE ADMINISTRATION
West Fargo Public School

Student_____ DOB_____ Grade_____

School_____ Teacher_____

Medication/Procedure_____ Dose_____

From_____ 20____ To_____ 20____

See "PRESCRIPTION or Over the Counter & AUTHORIZATION FOR MEDICATION ADMINISTRATION" or "AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURES". Attach this to the appropriate form for instruction and reference.

Date	**Time In /Out**	**Comments**	**Initials**

Ab=Absent Re=Refused Ns=No Show Dc=Discontinued Ch=Changed

Signatures_____ _____

_____ _____