

UNIVERSITY OF TEXAS AT AUSTIN SCHOOL OF NURSING
ADN-BSN PROGRAM
PHARMACOLOGY INFORMATION FORM

Student Name: _____

Name of ADN or Diploma Program and graduation date: _____

Years of Practice: _____

Pharmacology course number from nursing program: _____

1. How long has student been administering medications at your facility? _____

2. What type/age of clients are on this nursing unit? _____

3. Does student have direct responsibility (giving medications) or indirect responsibility (supervising others who give medications) for medication administration? _____

4. What is the frequency of student's medication administration? (Please check one)
_____ Daily _____ Weekly _____ Monthly _____ Rarely

5. Please check the categories of medications which the student administers most frequently:

A. Anti-infectives _____ B. Cardiac Medications _____

C. Hypnotics _____ D. Psychotropics _____

E. Respiratory _____ F. Pain Medications _____

G. Sedatives _____ H. Hormonal Medications _____

I. Anti-inflammatory _____ J. Chemotherapy _____

K. Other: _____

Name of Person Completing Form (please print): _____

Signature: _____

Title: _____

Agency: _____

Please mail completed form to:

UT Austin School of Nursing
Office of Student Affairs
ADN-BSN Program
1700 Red River
Austin, TX 78701

For ADN-BSN Program Use Only

Approval Status: Yes _____ No _____ Comments: _____

Signature: _____ Date: _____