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: __________________________