MEDICATION RECORD

School Year
School: ☐ Prescription ☐ Non-prescription

School Staff : Notify SN of new med? ________
Receive parent permission to give medication? ______

PHYSICIAN AUTHORIZATION *(To be completed by the Physician)*

Student: ______________________ DOB: ____________

Name of Medication: ________________ Generic OK? ____ Dosage/Route ____________ Time: __________ or every ________ hours.

Reason medication is prescribed: ______________________ Start Date: __________ Stop Date: __________

Significant information/Instructions/Contraindications: ______________________

Licensed Health Care Provider Signature: ________________ **Date:** ________ **Phone:** ________ **Fax:** ________

DAILY MEDICATION LOG

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug.																															
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															
June																															

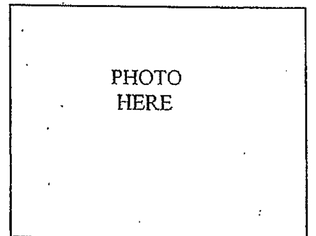
Initials Name   Initials Name   Initials Name

Initials Name   Initials Name   Initials Name

School Nurse: ______________________ Review date ________

Acceptable Codes: AB=absent **SD**=School Delay
ED=Early Dismissal **NS**=No School **FT**=Field Trip
NMS=No medication at school **DC**=Discontinue medication

Variance Codes: VO=Omitted Dose **VW**=Wrong Child
VD=Wrong dose/amount **VM**=Wrong medication
VT=Wrong Time **VR**=Wrong Route **VS**=Student Refused



C. Parent Request for Medication to be given during school Hours
(Parent, please complete and return form to the Main Office at your child's school)

I hereby give permission for my child, ______________________________ to receive medication during school hours. As the parent/guardian, I assume the responsibility of any adverse reactions this medicine may cause for my child. I agree to bring the prescribed medicine in a container properly labeled by a pharmacist. Nonprescription medicine will be brought in a sealed, original container.

Signature of Parent or Guardian ______________________ Date ______________________

Home telephone number ______________________ Work telephone number ______________________

Emergency Contact ______________________ Emergency telephone number ______________________

I give permission for the school to fax this Medication Record to my child's health care provider (if needed). I give permission for my child's health care provider to fax this form back to the school. I understand the school cannot guarantee the confidentiality of the fax machine.

Signature of parent or guardian ______________________ Date ______________________

D. Medication Check-In/Check Out Log

Date	Medication/Dose	Amount Received	Received by (Signature)	Signature of Witness

E. Medication Disposal/Destroyed Log (If not picked up)

Date	Medication	Amount	Signature of RN	Signature of Witness