School Year: ___________________________
School: ________________________________

MEDICATION RECORD
☐ Prescription ☐ Non-prescription

Order good for up to end of one school year
*****Medication Expiration Date: _____________________*****

PHYSICIAN AUTHORIZATION *(To be completed by the Physician)* **Student**: ______________________________ DOB: ____________________

Name of Medication: ______________________ Dosage/Route __________________ Time: ____________ or for PRN, 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 T=tardy 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

PHOTO
HERE

Parent, please complete each section, sign and return form to the Main Office at your child's school.

Authorization for Medication Administration

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 with student's name written on container.

Signature of Parent or Guardian ______________________________ Date ______________________________

Home telephone number ______________________________ Work telephone number ______________________________

Emergency Contact ______________________________ Emergency telephone number ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION good for _______school year.

I hereby authorize (physician's name)____ to release to the school nurse or principal, specific, confidential medical information contained in his/her record about my child. This information will be used by school staff to deliver health care services to my child in school.

Child's Name: ____ Birth Date_________________

To: ______________________________ _______________ ______________________________

Name of School Date Parent/Guardian's Signature

AUTHORIZATION TO FAX MEDICAL INFORMATION

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

Medication Check-In/Check Out Log

Date/Time	Medication/Dose	Amount on Hand	Amount Received	Total	Received by (Signature)	Signature of Witness

Medication Returned to Parent/Guardian

Date	Medication	Amount	Parent/Guardian Signature	Signature of Witness

Medication Disposal/Destroyed Log (If not picked up)

Date	Medication	Amount	Signature of RN	Signature of Witness