School Year: **2020-2021** **MEDICATION RECORD** Order good for up to end of one school year

School: _____ ☐ Prescription ☐ Non-prescription ***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.																															
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May																															
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_____ _____ _____ _____ _____ _____

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