

**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	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

School Year: 2017-2018

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    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

