School Year: 2024-2025
School: **The Franklin School of Innovation**

MEDICATION RECORD
Prescription or Non-prescription

Order good for up to the 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/Parameters for Administration/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.																															
April																															
May																															
June																															

_____ _____ _____ _____
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

Add Picture Here