

School Year: 2023-24
 School: _____

MEDICATION RECORD

Order good for up to end of one school year.

Prescription Non-prescription

Medication Expiration Date: _____

PHYSICIAN AUTHORIZATION *(To be completed by the Physician)* Student: _____

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																																
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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

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