MCDOWELL COUNTY SCHOOLS (Traditional Plan) **MEDICATION RECORD** **SCHOOL YEAR:** _____

Student: _____ DOB: _____ School :_____ Teacher _____

PHYSICIAN AUTHORIZATION *(To be completed by the Physician)* □ Prescription □ Non-prescription *** Expiration Date _____***

Name of Medication: _____Dosage _____ Time: _____ or for PRN, every _____ hours. Route (circle) PO INJ TOP INH REC

Reason medication is prescribed: _____ Start date: _____ Stop Date: _____(not past end of school yr)

Significant information/Instructions/Contraindications: _____

Has student been instructed in use of medication and demonstrated necessary skill level _____ Yes _____ No

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
July																															
Aug.																															
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															
June																															

_____ _____ _____ _____

Initials Name Initials Name

_____ _____ _____ _____

Initials Name Initials Name

_____ _____ _____

School Nurse Initials Date

Acceptable Codes : AB=Absent SD=School Delay
ED=Early Dismissal NS-No School FT=Field Trip
NMS=No Medication At School R=Refused Medication
O=Omitted or unabe to locate student

Route Codes: PO=by mouth INJ=Injection
TOP=Applied to top of skin INH=Inhaled REC=Rectal

PHOTO HERE

Student: _____ **School** _____ **School Year:** _____

Parent Request for Medication to be given during school hours

(please complete and return form to the Nurse office at your child's school)

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 medication may cause for my child. I agree to bring the prescribed medication in a container properly labeled by a pharmacist. Nonprescription medicines will be brought to school in a sealed, original container.

_____ _____ _____ _____

Signature of Parent / Guardian | Date | Phone | Cell/Work phone

_____ _____ _____ _____

Emergency Contact | Phone | Cell | Work

I give permission for the school Nurse or Staff and Physician's office to transfer information about my child's condition. I also give permission for the school and health care provider to fax to each other. I understand the school cannot guarantee to confidentiality of the fax machine.

_____ _____

Parent or Guardian Signature | Date

Please check one: ☐ School to administer ☐ Self-administer (emergency meds only)

_____ _____

Student signature for self carry | Date | Nurse signature | Date

New Medication Brougt to School

Date	Dosage	Amount	Received By Signature	Witness Signature

Medication Discarded/Picked-up ☐ **Check if destroyed and not picked up**

Date	Amount	By Whom	Witness

Medication Nursing Documentation

Yes	No	Item
____	____	Emergency Action Plan
____	____	Student name on container
____	____	Demostrates correct use
____	____	Understands dosage and times
____	____	Second labeled med at school

SH-MAF1 Approved 5/20/2011 Updated 4/22/2013