

2023-2024 SCHOOL YEAR MEDICATION LOG

DO NOT DESTROY

Entries are Computerized

SCHOOL: TERRAMAR

Student Name:		M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
		31	1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31	
	JULY AUG																									
Teacher: Room No:						1	4	5	6	7	8	11	12	13	14	15	18	19	29	21	22	25	26	27	28	29
Grade:	SEP																									
Diagnosis:		2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	23	25	26	27	30	31			
	OCT									ER K-12	ER K-12															
Medication:				1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	
Dosage:	NOV																									
Frequency:						1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
Daily PRN (Circle)	DEC														ER HS	ER K-12										
Physician's Name Tel. No.		1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31		
	JAN		Staff Dev. Day																							
Medication Reconciliation:				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29		
Count Date	FEB								ER K-8	ER K-8																
Count Date					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29	
Count Date	MAR																									
Count Date		1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30			
Count Date	APR																									
Count Date				1	2	3	6	7	8	9	10	13	14	15	16											
Count Date	MAY														ER K-12											

Comments:

A=Absent ■=Holiday/no school
■=90 min Early Release
F=Field Trip #s=time given.
Initials=person administering Rx
X=Taken as directed
Blank=No Med. Given
B=Bottle sent home for refill
NMH-No med. Here
ER=Early Release

Nurse's Signature & Title	Initials	Designee Signature & Title	Initials	Student Name:
				Dose Time:
				ER days: give/hold

DEER VALLEY UNIFIED SCHOOL DISTRICT # 97**PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL**

I request that the school nurse or my agents (Principal/Designee) see that

_____ receives this medication from _____ to _____
 Student's Name Date

_____ at _____ for _____
 Date Time Reason for Medication

Medication	Dosage
This medication is furnished by me, and if it is prescription*, it is in its original pharmacy bottle, labeled with my child's name, prescription number, and identification of medication. If it is an over-the-counter medication, it is to be in its original container. The date, time given, and amount given should be entered above. School district personnel will not be responsible or liable for any reaction to medicines given according to the above direction. All medication will be kept in a locked cabinet in the nurse's office and dispensed from there. I understand it is my responsibility to monitor medication supply and provide additional medication when needed.	

*If the medication is a sample given by the physician, please provide a signed note from the physician telling who the medication is for, the date, and instructions for giving the medication.

I understand that my child may receive medication administered by a nursing student, under the direct supervision of the school's nurse, and give my consent for this.
 Please initial one: Yes _____ No _____

Other medications currently taken by my child: _____

 PARENT'S SIGNATURE

 DATE SIGNED

 TEACHER

 GRADE

Contact Email: _____

3/2023

For Office Use: Doctor Order Received _____

_____ Date

Medication Brought to School

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

DATE _____ AMT _____ SIGNATURES _____ / _____

EARLY RELEASE DAYS

I request my student **RECEIVE / DOES NOT RECEIVE** medication at School on early release days. (circle appropriate answer)

Parent Signature _____

END OF YEAR MEDICATION DISPOSITION

AT THE END OF THE NEED OR THE END OF THE SCHOOL YEAR:**

Please initial one of these statements:

_____ I WILL PICK UP MY STUDENT'S REMAINING MEDICATION.

_____ PLEASE DESTROY ANY REMAINING MEDICATIONS.

**DISCONTINUED MEDICATIONS WILL BE RETAINED FOR THREE DAYS, THEN DESTROYED. MEDICATIONS NOT PICKED UP WITHIN ONE DAY OF THE END OF SCHOOL YEAR WILL BE DESTROYED.

Date picked up _____ Signature _____

Date meds destroyed _____

Amount picked up _____