

2018– 2019 SCHOOL YEAR MEDICATION LOG`
DO NOT DESTROY *Entries are Computerized*

SCHOOL: Bellair Elementary

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
				1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Teacher: Room No:	AUG			■	■	■	■														ER					
Grade:		3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28					
Diagnosis:	SEP	■					■									ER										
Medication:		1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31		
Dosage:	OCT					■	■				ER				ER	ER										
Frequency:					1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30
Daily PRN (Circle)	NOV					ER						■							■	■	■					
Physician's Name Tel. No.		3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31				
	DEC					ER										ER	■	■	■	■	■	■				
Medication Reconciliation:		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31		
Count _____ Date _____	JAN		■	■	■	■											■				ER					
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 _____	FEB								■						ER	ER	■									
Count _____ Date _____						ER											■	■	■	■	■					
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					ER										■	■									
Count _____ Date _____				1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Count _____ Date _____	MAY					ER														ER		■				
Comments:																										

A=Absent ■=Holiday/no school
 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

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 DISPOSITON

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 _____

