

**2022-2023 SCHOOL YEAR MEDICATION LOG**

**SCHOOL:**

Mountain Ridge High School

**DO NOT DESTROY**

*Entries are Computerized*

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

<b>Nurse's Signature &amp; Title</b>	<b>Initials</b>	<b>Designee Signature &amp; Title</b>	<b>Initials</b>	<b>Student Name:</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	<b>Dose Time:</b>
_____	_____	_____	_____	<b>ER days: give/hold</b>

**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:** \_\_\_\_\_

4/2022

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 \_\_\_\_\_