PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

TO BE COMPLETED BY HEALTH CARE PROVIDER
(FOR PRESCRIPTION or OVER-THE-COUNTER MEDICATION)

(Complete one form per medication: Prescription or Over-the-counter medication.)

Name of Student: _____ **Date of Birth:** _____

Medication: _____ **Reason for medication:** _____

Dosage: _____ **Route:** _____ **Time:** _____

If 'as needed' (PRN), indicate when dose can be repeated: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Name of Health Care Provider (print): _____

Signature of Health Care Provider with Prescriptive Authority: _____

Office Phone Number: _____ **Fax:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and give permission to Academy District 20 to administer medication to my child. ***I understand that whenever possible, medication should be administered at home.*** I understand that it is my responsibility to provide the medication in the original labeled container marked with my child's name. **Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.**

I give my permission for the school staff to contact the prescribing physician regarding this medication. I release Academy District 20 and its staff from any claim which may arise out of the administration or failure to administer medication to my student.

Name of Parent/Guardian (print): _____
Medicaid? No_____**Yes**_____ **Medicaid #** _____
Home phone: _____ **Other phone numbers:** _____
Signature of Parent/Guardian: _____ **Date:** _____

Date Form Revised: 4/26/10

Student Name and #

2015-16 Medication Log

Teacher/Team

Medication_____ Dosage_____ Route_____ Time(s)_____

	Week One					Week Two					Week Three					Week Four					Week Five				
	M	**Tu**	**W**	**Th**	**F**	**M**	**Tu**	**W**	**Th**	**F**	**M**	**Tu**	**W**	**Th**	**F**	**M**	**Tu**	**W**	**Th**	**F**	**M**	**Tu**	**W**	**Th**	**F**
Aug.	17	18	19	20 H	21 H	24	25	26	27	28	31														
Sept.		1	2	3	4	7 H	8 H	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30		
Oct.				1	2	5	6	7	8 H	9 H	12	13	14	15 H	16 H	19	20	21	22	23	26	27	28	29	30
Nov.	2	3	4	5	6	9	10	11 H	12	13	16	17	18	19	20	23 H	24 H	25 H	26 H	27 H	30				
Dec.		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21 H	22 H	23 H	24 H	25 H	28 H	29 H	30 H	31 H	
Jan.					1 H	4 H	5 H	6	7	8	11	12	13	14	15	18 H	19	20	21	22	25	26	27	28	29
Feb.	1	2	3	4	5	8	9	10	11	12 H	15 H	16	17	18	19	22	23	24	25	26	29				
Mar.		1	2	3	4	7	8	9	10	11 H	14	15	16	17 H	18 H	21 H	22 H	23 H	24 H	25 H	28	29	30	31	
April					1	4	5	6	7	8	11	12	13	14	15	18	19	20 H	21	22	25	26	27	28 H	29 H
May	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30 H	31			
June			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	

Medication Counts

Date												
Count received												
Initials x2												

Comments:

CODES:
A Absent
H Holiday
N No Meds
L Late start
S Snow day
D Discontinued
R Refused

ICD-9 code _____

Nurse's Signature_____( ) Signature_____( ) Signature_____( )
initials initials initials