HCPS 2018-2019 OVER-THE-COUNTER MEDICATION LOG

Student: _____

School _____ **Grade**: _____ **HR** _____

1. Record time & initial in appropriate box when medication is given 2. Record **AB** for absent, **FT** for Field Trip, **NM** for NO medication 3. Include form in health record if pupil transfers to another school

DIAGNOSIS	PHYSICIAN'S NAME	MEDICATION	DIRECTIONS FOR ADMINISTERING	SIDE EFFECTS

	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
September						3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28
Time/Initial						H												H							
October	1	2	3	7	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31		
Time/Initial						H																			
November				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30
Time/Initial							H											H	H	H					
December	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31				
Times/Initial														H	H	H	H	H	H	H	H				
January		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31	
Time/Initial		H	H													H					H				
February					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	
Times/Initial																H									
March					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
Times/Initial																									H
April	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30			
Times/Initial	H	H	H	H	H										H	H									
May		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31	
Times/Initial																					H				
June	3	4	5	6	7	10	11	12	13	14	17	18	19	20		24	25	26	27						
Times/Initial										H															
July	1	2	3	4		8	9	10	11		15	16	17	18		22	23	24	25		29	30	31		
Times/Initial				H																					
August				1		5	6	7	8		12	13	14	15											
Times/Initial																									

Please sign, put your title and initials in the appropriate lines below

RN/LPN Nurse _____ Substitute _____ Substitute _____

Signature Title Initials Signature Title Initials Signature Title Initials

Print

OVER-THE-COUNTER MEDICATION REQUEST

Student: _____

DOB: _____

Medication: _____

Dosage: _____

Frequency: _____

Duration: _____

Reason for medication: _____

_____

_____

I, _____, the parent/legal custodian of _____, request that the school nurse or principal's designees administer this medication to the above named student during school hours and at the times indicated. I agree to furnish said medication in an unopened, **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

Any nonprescription medication that is to be given for more than three (3) consecutive school days must be authorized in writing by a physician. If medication dosage exceeds recommended dosage/age a physician's note is requested.

Date _____ _____

Signature of Parent/Legal Custodian
Home Tel. No. _____
Work Tel. No. _____

NOTE: PLEASE RETURN THIS FORM WITH MEDICATION TO YOUR CHILD'S SCHOOL.

PHYSICIAN TO COMPLETE IF: (please circle appropriate statement)

1. ○ MEDICATION IS TO BE GIVEN FOR MORE THAN THREE (3) CONSECUTIVE SCHOOL DAYS

OR

2. ○ DOSAGE REQUESTED BY PARENT EXCEEDS RECOMMENDED DOSAGE / AGE ON LABEL

_____ _____
Signature of Physician **Date**

_____
Printed signature of Physician

Telephone No. _____

Date Received	Medication	Received From	Exp. date

Nurse signature_____
Date

Revised 4/18

Print