HCPS 2017-2018 PRESCRIPTION MEDICATION LOG

School _____ Student: _____

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

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

RN/LPN _____ Substitute _____ Substitute _____

Signature Title Initials Signature Title Initials Signature Title Initials

MEDICATION PERMISSION FORM

Received	Medication & Pill Count	Received From	Exp. Date

Nurse signature _____

Date

TO BE COMPLETED BY PHYSICIAN

I certify that, in my opinion, it is medically necessary that the medication described below be administered to _____ _____during school hours and that this medication may be administered by school personnel.

Prescription:

Medication _____

Dosage & Time _____

Duration _____

Date of Prescription _____

Diagnosis requiring medication _____

Date _____ _____

Signature of Physician

Phone#_____ _____

Printed Physician signature

TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN

I, _____, the parent or legal custodian of _____request that the clinic attendant, school nurse or principal's designees administer the above medication to the above named student during the school hours and at the times indicated. I agree to furnish said medication in the **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.

Date _____ _____

Signature of Parent/Legal Custodian

Home Tel. No. _____

Work Tel. No. _____

NOTE: PLEASE RETURN THIS FORM WITH MEDICATION OR HAVE YOUR PHYSICIAN MAIL OR FAX IT BACK TO YOUR CHILD'S SCHOOL, ATTN: CLINIC ATTENDANT/SCHOOL NURSE