### HCPS 2019-2020 OVER-THE-COUNTER MEDICATION LOG

**Student:** ____________________________

**School:** ____________________________

**Grade:** ____________ **HR:**

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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.

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<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>PHYSICIAN’S NAME</th>
<th>MEDICATION</th>
<th>DIRECTIONS FOR ADMINISTERING</th>
<th>SIDE EFFECTS</th>
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<td>September</td>
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<td>Time/Initial</td>
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<td>Time/Initial</td>
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<td>August</td>
<td>3 4 5 6 10 11 12 13 17 18 19 20</td>
<td>Time/Initial</td>
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</tbody>
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Please sign, put your title and initials in the appropriate lines below:

RN/LPN Nurse ____________________________

Signature: ____________________________

Title: ____________________________

Initials: ____________________________

Substitute ____________________________

Signature: ____________________________

Title: ____________________________

Initials: ____________________________

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**Diagnosis:** ____________________________

**Physician’s Name:** ____________________________

**Medication:** ____________________________

**Directions for Administering:** ____________________________

**Side Effects:** ____________________________
OVER THE COUNTER PERMISSION FORM

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 # ______________________

Date

<table>
<thead>
<tr>
<th>Date Received</th>
<th>Medication Name</th>
<th>Quantity Received</th>
<th>Received from</th>
<th>Exp. Date</th>
<th>Nurse initials</th>
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Entered into Welligent _______ (Initials)
Scanned into Welligent _______ (Initials)

Nurse signature________________________________________ Date ___________