HCPS 2021-2022 PRESCRIPTION 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			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**											
October					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
Time/Initial											**H**														
November	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30			
Time/Initial		H		**H**														H	H	H					
December			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Times/Initial																H	H	H	H	H	H	H	H	H	H
January	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31				
Time/Initial											**H**							**H**							
February		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28				
Times/Initial																**H**									
March		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																									
April					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
Times/Initial					**H**	H	H	H	H	H						**H**									
May	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31			
Times/Initial		**H**																			**H**				
June			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23		27	28	29	30	
Times/Initial															**H**										
July	4	5	6	7		11	12	13	14		18	19	20	21		25	26	27	28						
Times/Initial	H																								
August	1	2	3	4		8	9	10	11		15	16	17	18											
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

Date Received	Medication Name	Quantity Received	Received from	Exp. Date	Nurse initials

Initial: **entered in Welligent _____ Scanned into Welligent _____**

Nurse signature _____

Date_____

Medication count: **actual # (amount) = # shown in Welligent**

Name/initial_____ Name/initial_____

Sept. ____/___ Oct._____/____ Nov.____/____ Dec.____/____
Jan. ____/____ Feb. ____/____ Mar.____/____ April ____/____
May____/____ June____/____ July____/_____ Aug.____/_____

Please use for medication count reconciliation:
Date: _____
Date:_____
Date:_____
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: SCHOOL NURSE