CodeRVA Regional High School
Prescription Medication Log

Student Name: _____ Grade Level: _____ Morning Meeting: _____

2.) Record time and initial in the 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	R	F	M	T	W	R	F	M	T	W	R	F	M	T	W	R	F	M	T	W	R	F
Aug.					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
Time/ Initials					NS	NS	NS	NS	NS	NS	NS	NS	NS		NS										NS
Sep.	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30			
Time/ Initials	NS																NS								
Oct.			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Time/ Initials				NS													NS								
Nov.	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28					
Time/ Initials	NS	NS																NS	NS	NS					
Dec.	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31		
Time/ Initials																NS	NS	NS	NS	NS	NS	NS	NS		
Jan.				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30
Time/ Initials				NS	NS										NS	NS									
Feb.	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27					
Time/ Initials											NS														
Mar.	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31			
Time/ Initials				NS											NS						NS	NS			
Apr.			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	
Time/ Initials			NS	NS	NS															NS					
May					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
Time/ Initials															NS						NS				
Jun.	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30			
Time/ Initials	NS	NS	NS	NS	NS					NS				NS	NS					NS					
Jul.			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Time/ Initials				NS	NS					NS					NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS

Personnel _____ Personnel _____ Personnel _____

Signature / Title / Initials Signature / Title / Initials Signature / Title / Initials

MEDICATION PERMISSION FORM

Medication	Quantity Received	Exp. Date

Personnel 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 director'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 fully intact. I understand and accept that the CodeRVA 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 SCAN IT BACK TO YOUR CHILD'S SCHOOL AT GINA.FOX@CODERVA.ORG

Revised 7/18