CodeRVA Regional High School
Over-the-Counter Medication Log

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

1.) 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

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

Entered into Welligent _____ **(Initials)**

Scanned into Welligent _____ **(Initials)**

Nurse signature _____
Date