Descriptor Code: ACBD-E5

RECORD OF MEDICATION

8/9/18

USE A SEPARATE FORM FOR EACH MEDICATION

STUDENT'S PICTURE	**STUDENT'S NAME**		
	DATE OF BIRTH		
	SEX	☐ Male ☐ Female ☐Transgender	
	GRADE		
HEALTHCARE PROVIDER PHONE NUMBER(S)	Name: Name of Practice: Phone Number:		Name: Name of Practice: Phone Number:
PARENT/GUARDIAN EMERGENCY CONTACT NUMBER	Name: Relationship to student: Phone number:		Alternative contact: Relationship to student: Phone number:
LIST ALL KNOWN ALLERGIES			
NAME OF MEDICATION PROVIDED AND POSSIBLE SIDE EFFECTS (Use a separate form for each medication)	Name of Medication: Side effects:		
IS DISPENSING EQUIPMENT REQUIRED?	☐ Yes (If yes, please list below with any storage instructions) ☐ No		
IS STUDENT TAKING MEDICATIONS OTHER THAN LISTED ABOVE?	☐Yes (If yes, please list names, side effects, and steps to avoid negative interactions between medications) ☐ No		
	1. Name of medication Side effects: Steps to avoid negative interactions:		3. Name of medication Side effects: Steps to avoid negative interactions:
	2. Name of medication Side effects: Steps to avoid negative interactions:		4. Name of medication Side effects: Steps to avoid negative interactions:

STUDENT'S NAME:	
DOB:	
MEDICATION:	

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DIRECTIONS: Use your initials to document when you provided medication or a code from below to indicate why medication was not provided.

Date	Time	Dose	Route	Code	Notes	Initials

Eligible and Authorized School Medication Providers: Signature/Initials

S:	I:
S:	I:
S:	I:
S:	I:

CODES

(A) Absent
(ED) Early Dismissal
(F) Field Trip or Activity Off-Campus
(N) No medication available*
(R) Refused*
(X) No School

*Contact student's parent/guardian as soon as possible.