The Villages Charter School Consent Form & Student Medication Administration Record

(To be completed for each medication)

School Year _____

Name of Student _____ Date of Birth _____ Sex _____

Grade/Home Room (or Teacher) _____ Name of School _____

Physician _____ Allergies: _____

Name and Dosage of Medication _____ Route _____ Frequency _____

Time(s) Given in School _____

I hereby grant permission to _____ designated school health personnel to assist in the administration of prescribed medication and/or treatment to my child while in school. It is my responsibility to notify the school if and when these orders change. **Signature of Parent/Guardian:** _____ **Date:** _____

Initial & Time of administration: a complete signature and initials of each person administering medications should be documented on next page.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30 31
AUG																														
SEPT																														
OCT																														
NOV																														
DEC																														
JAN																														
FEB																														
MAR																														
APR																														
MAY																														

Medication Log Continued

CODES*

(A) Absent (O) No Show (F) Field Trip (W) Dosage Withheld (N) No Medication Available (H) Holiday (FB) Fall Break (WB) Winter Break

(S)-Summer Break (PD) Professional Development (*) Bad Weather Day

INITIAL SIGNATURE (of person administering medication)

1. _____ _____ 2. _____ _____

3. _____ _____ 4. _____ _____

5. _____ _____ 6. _____ _____

Medication Counts: On Hand/# Received or Returned/Total/Initials (Nurse/ Parent)

Date/Time	On Hand	# Received +/Returned -	Total	Initials (Nurse & Parent)