School Year 2023-2024 **Jim Ned CISD Medication Administration Log** **SCHEDULED DAILY MEDICATION**

Student: _____ **Date of Birth:**_____ **Grade:**_____ **Teacher:**_____ **Consent Rec'd:**_____

Name and Dosage of Medication:_____ _____ **Route:**_____ **Frequency:**_____

Directions: Initial time of administration. Complete signature and initials of each person administering medication should be included below.

	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
Time																															
Aug	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X						X	X				
Sept		X	X	X					X	X						X	X						X	X					X	X
Oct	X						X	X	X					X	X						X	X					X	X	X	
Nov				X	X						X	X						X	X	X	X	X	X	X	X					X
Dec		X	X						X	X						X	X				X	X	X	X	X	X	X	X	X	X
Jan	X	X	X	X	X	X	X	X					X	X	X					X	X						X	X			
Feb			X	X						X	X						X	X	X					X	X					X	X
Mar		X	X						X	X	X	X	X	X	X	X	X						X	X				X	X	X
Apr	X					X	X						X	X						X	X					X	X	X			X
May				X	X						X	X						X	X					X	X	X	X	X	X	X

Initials: **Signature:**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

Codes:

A - Absent
E - Early Dismissal
F - Field Trip
N - No medication Available
DC - Discontinued
O - No Show
W - Dosage Withheld
X - No School (weekend, holiday, bad weather, etc)
* - See notes on back

Received Medication:

Date:_____ Number of pills Received:_____ Received by:_____ Signature of Parent/Guardian:_____

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Request for Administration of: Prescription and Non-Prescription Medication by JIM NED CISD Personnel

Name of Student_____ Grade/Teacher _____

Name of Medication: _____ Condition for which medication is to be given: _____

Method of administration at school only: Time: _____ Dosage: _____ Special Instructions:_____

Physician's Name (Print):_____ Physician's Signature: _____

Please initial each statement:

- ____ Parent/Guardian must provide signed documentation from a medical provider for Over the Counter medication to be administered **longer than 3 consecutive days.**
- ____ Medication that is prescribed for "three times a day"/ "every 8 hours" or less **WILL NOT BE** administered at school.
- ____ Medication **may not be scheduled** for other than school hours (Medications scheduled before the first Tardy bell and after the last bell will **NOT** be administered)
- ____ Medication may be administered by a non-medical designee of the principal.
- ____ All medication must be in the **original container** (NO BAGGIES) and will be administered according to prescriber/manufacturer directions.
- ____ **ANY and ALL** changes in medication administration **MUST be received in writing or by Telephone Call Directly to the School Nurse from parent/guardian**
- ____ **Jim Ned CISD does NOT provide any medication to students,** except emergency medications for severe allergic reactions such as Diphenhydramine HCl and/or Epinephrine (i.e. Benadryl and/or Epi-Pen)

WITH THIS UNDERSTANDING I REQUEST THE STATED MEDICATION BE ADMINISTERED TO THE ABOVE NAMED CHILD.

Parent or Legal Guardian Signature: _____

Date: _____ Phone Number: _____

Revised 3/2023

Notes: