DAILY MEDICATION LOG

Student Name: _____ **Date Of Birth:** _____ **Class**_____

Medication: _____ **Dose:** _____ **Time:** _____ **Route** _____

Start Date: _____ **End Date:** _____

Week of:					Week of:					Week of:					Week of:					Week of:				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Week of:					**Week of:**					**Week of:**					**Week of:**					**Week of:**				
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F

CODES

NS =no school **A** =absent **OM** =out of medication **M** =missed dose **R**=refused (see comments on back)

Nurse (Print_____Signature _____Initials_____

Staff (Print)_____Signature _____Initials_____

Staff (Print)_____Signature _____Initials_____

Staff (Print)_____Signature _____Initials_____

DAILY MEDICATION LOG

Student Name: _____ **Date Of Birth:** _____ **Class**_____

COMMENTS / SPECIAL INSTRUCTIONS (Date and Sign all entries):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Intake and Count for All Medication

Note- All controlled medications must be counted and verified by two medication trained staff members or by one staff member and parent (i.e.: Ritalin, Dexedrine and Tylenol with codeine)

Date	Name of Medication and Dosage	Expiration Date	Amount Received	Parent Signature	Staff Initials

Nurse (Print_____Signature _____Initials_____
Staff (Print)_____Signature _____Initials_____
Staff (Print)_____Signature _____Initials_____
Staff (Print)_____Signature _____Initials_____