Medication Administration Daily Log - **To Be Completed for EACH Medication Dose** **School Year: 2025/ 2026**

Student Name: _____ Grade: _____ Teacher: _____

Medication: _____ Dosage: _____ Route: _____ Frequency: _____ Time to be given: _____

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
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Directions: Put Initials of who administered with time of administration.

A) Absent **E)** Early Dismissal **F)** Field Trip **N)** No Medication **PG)** Parent Gave **W)** Withheld **X) No** School **TH)** Taken at Home **NA**) Not Applicable **V**) Virtual

Medication Administration Authorization Form

(To be completed for **Each** medication, **this form may be photocopied for additional copies**)

Date to begin: _____

❏ Over the Counter (OTC) **Expiration Date:** _____ Medication will Need to be Refrigerated? Yes / No
❏ Prescription (Prescription #): _____ Medication will Need to be Refrigerated? Yes / No
Prescriber Name: _____ Phone: _____ Pharmacy Name: _____ Phone: _____

Name of Medication: _____ Dosage: _____ Time(s) to be administered: _____
Purpose of Medication: _____ Possible Side Effects: _____
Instructions: _ _____

● **Carrollton R-VII School District will not** administer any medication that is not regulated by the U.S. Food and Drug Administration without a written directive from the healthcare provider that states why the medication must be administered at school and a signed consent from the parent/legal guardian. The district expects parents/legal guardians to administer medications at home or by coming to the school to administer medications themselves when possible. Medications will be administered at school only when it is not possible or effective for the student to receive the medication at home. (prescriptions or any medications that have a **DRUG FACTS label** present on a manufacturer package will require a consent for administration by parent/legal guardian).

● **All medications include prescription drugs, over-the-counter (OTC), including herbal preparations, vitamins, and or medications that claim or purport to be medicinal or performance enhancing, including essential oils must be provided by the parent/legal guardian. All medications must be delivered to and from the school office by a parent/legal guardian.** Unused medications may be picked up at any time during school hours throughout the year by a parent/legal guardian. Medications not picked up by the end of the school year will be disposed of.

● **Medications prescribed by a physician must be administered as the physician ordered**. The first dose of any medication will **not** be given by school personnel, except for the medications that are used only in an emergency situation. **Prescription medications will be administered ONLY:** if it is in the original container with a current pharmacy label with a prescription date, the child's full name, name of the drug and dosage, times to be given and physician's name. A signed consent from parent/legal guardian is required.

● **Over the Counter (OTC), including herbal preparations, vitamins, and or substances that claim or purport to be medicinal or performance enhancing, including essential oils may be administered ONLY:** if the medication is in the original manufacturer packaging with a current date of expiration (not expired). The medication will be given only as directed on original manufacturer packaging unless specific written instructions from a physician are provided. Medications must have the child's full name labeled on the medication. A signed consent from parent/legal guardian is required.

● **Field trips/school related events off campus - Only scheduled daily medications and emergency medications (inhalers, epi pens, Benadryl, etc.) will be sent with teachers /staff. Special requests are required in writing if other medications are needed for your child /children.**

I give permission for _____ to receive the above medication at school.

(student's name)

I request the nurse or designated district staff member to give the above listed medication. I give district personnel permission to contact the student's physician directly to provide information on the student's condition or to clarify medication administration instructions**. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease. I have given the first dose of this medication. I also understand that any medication left after the last day of the current school year will be disposed of.**

Parent/Legal Guardian: _____ (Home) _____ (Cell) _____

Date	# pills/bottle received	Nurse/Health Aide	Parent/legal guardian	Comments:
Date	# of pills returned/destroyed	Witness 1	Witness 2	Comments:

Note: Persons administering medication should initial and sign below.

1. _____ _____ **Comments:**
initial signature

2. _____ _____
initial signature

3. _____ _____
initial signature

Revised 08/24