CCSD Medication Permission & Intake Form

Student:_____**DOB:**_____ **School Building/Grade:**_____

MEDICATION:_____ **Dose/Unit:**_____

Route:_____**Frequency:**_____**Time at School:**_____**Time at Home:**_____

Starting Date:_____**Physician:**_____**Phone:**_____

Diagnosis:_____**Side effects:**_____

Special Instructions:_____ **Expiration/Stopped Date:**_____

Parent/Guardian Name: _____**Phone:**_____

Parent/Guardian Inititals_____**Parent/GuardianSignature:**_____

Medication Intake Log:

Date														
No. on hand														
No. received														
Received by														
Brought in by														

Initials	First and Last Name, Credentials	Initials	First and Last Name, Credentials	Initials	First & Last Name, Credentials
_____	_____	_____	_____	_____	_____

Special Circumstances:

_____

Student Name: _____ DOB: _____

Medication Returned:

- Date:_____ No. Returned _____ Reason:_____

  Person Receiving Medication: _____

  Health Secretary/Nurse Signature: _____

- Date:_____ No. Returned _____ Reason:_____

  Person Receiving Medication: _____

  Health Secretary/Nurse Signature: _____

Medication Given to SRO to Destroy:

Date:_____ No. Destroyed: _____

Reason: _____

Heath Sect/Nurse Signature:_____

Notes: _____

_____

Medication Wasted:

- Date:_____ No. Wasted _____ Reason/situation:_____

Health Secretary/Nurse Signature: _____ Witness Signature: _____

- Date:_____ No. Wasted _____ Reason/situation:_____

Health Secretary/Nurse Signature: _____ Witness Signature: _____

CONSENT FOR EXCHANGE OF INFORMATION: I give permission for the parties named below to exchange written and verbal information regarding the above-named student with personnel at CCSD. If this medication is for attention or behavior concerns, CCSD may send behavior checklists to the physician named below. This permission is good for one school year.

Other (specify): _____

Name of physician: _____ Phone: _____

Parent/Guardian Signature_____DaytimePhone_____Date_____

Specific authorization for release of information protected by state or federal law:

My signature releases all information related to (check appropriate spot):

_____Mental Health/Psychological _____Substance Abuse _____HIV status/AIDS _____Other

Parent/Guardian Signature_____Date_____