

**MEDICATION CHECK-IN FORM**

*NOTE: To be completed by an eligible school medication provider prior to accepting medication from parent/guardian or authorizing a student to self-administer. If the answer to any question is "no," the district may defer the medication request until the parent/guardian provides the required information. If medication being checked in is emergency medication under NDCC 15.1-19-16, use form ACBD-E4 instead of this form.*

Medication was hand delivered by parent/guardian:  Yes  No  
*If no, collect medication, store as directed, and contact parent/guardian to come to school as soon as possible to verify medication request.*

Parent submitted **fully** completed authorization form:  Yes  No

- Appropriate documentation attached to form for students with allergies:  
 Yes  No  N/a
- If more than one medication is to be provided/authorized, information from healthcare provider on known interactions is included:  
 Yes  No  N/a
- If request is to provide/authorize over-the-counter medication in manner other than recommended by manufacturer, authorization from healthcare provider is included:  
 Yes  No  N/a
- Includes healthcare provider's signature for prescription medication:  
 Yes  No  N/a

Name of medication: \_\_\_\_\_  
 Prescription  Over-the-counter

Who is requested to provide medication?

- School personnel  Student under supervision  
 Student without supervision  
 Check here if request is for student to carry the medication.

*NOTE: Student must be issued a medication pass if s/he is to self-administer and/or carry medication.*

Route by which medication must be given:

- Mouth  Eyes  Ear  Nose  Topical (e.g., skin ointment)

Other: \_\_\_\_\_

*NOTE: If other, check with school administrator to determine if school is obligated/willing and has qualified personnel to provide medication. This provision is not applicable if request is for student to self-administer.*

Medication expiration date: \_\_\_\_\_

Was this listed on the medication container?  Yes  No

Amount of medication in container: \_\_\_\_\_

**EXHIBIT**

Descriptor Code: ACBD-E3

If parents provided medication at home, list amount given at home: \_\_\_\_\_

For over-the-counter medication:

- Medication in original manufacturer’s container  Yes  No
- Container lists medication’s name  Yes  No
- Container lists ingredients  Yes  No
- Container lists recommended dosage  Yes  No
- Container lists administration instructions  Yes  No
- Container lists storage instructions  Yes  No
- Container is labeled with student’s name and date of birth  Yes  No

If container is unsealed, it is labeled with amount of medication contained in it  Yes  No

For prescription medication:

- Medication in original pharmacy container  Yes  No
- Container lists pharmacy name and phone number  Yes  No
- Container or attached documentation lists active ingredients  Yes  No
- Container lists dosage  Yes  No
- Container lists storage instructions  Yes  No
- Container is labeled with student’s name and date of birth  Yes  No
- Container lists amount of medication dispensed  Yes  No
- Container lists administration instructions  Yes  No

If dispensing equipment is required:

- Did parent/guardian provide necessary equipment?  Yes  No
- Is the dispensing equipment clean and in good working order?  Yes  No
- Is the equipment labeled with the student’s name and date of birth?  Yes  No

List any storage instructions for dispensing equipment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of School Medication Provider (Printed)

\_\_\_\_\_  
Signature of School Medication Provider

\_\_\_\_\_  
Date

End of Yellowstone Exhibit ACBD-E3.....reviewed: 6/19/2023