EXHIBIT Descriptor Code: ACBD-E7

RECORD OF MEDICATION

USE A SEPARATE FORM FOR EACH MEDICATION

STUDENT'S PICTURE	**STUDENT'S NAME**				
	DATE OF BIRTH				
	SEX	☐ Male	☐ Female	☐Transgender	
	GRADE				
	NAMES AND LOCATION OF STUDENT'S TEACHERS BY PERIOD	1st		5th	
		2nd		6th	
		3rd		7th	
		4th		8th	
HEALTHCARE PROVIDER PHONE NUMBER(S)	Name: Name of Practice: Phone Number:		Name: Name of Practice: Phone Number:		
PARENT/GUARDIAN EMERGENCY CONTACT NUMBER	Name: Relationship to student: Phone number:		Alternative contact: Relationship to student: Phone number:		
LIST ALL KNOWN ALLERGIES					
NAME OF MEDICATION PROVIDED AND POSSIBLE SIDE EFFECTS (Use a separate form for each medication)	Name of Medication: Side effects:				
IS DISPENSING EQUIPMENT REQUIRED?	☐ Yes (If yes, please list below with any storage instructions) ☐ No				
IS STUDENT TAKING MEDICATIONS OTHER THAN LISTED ABOVE?	☐Yes (If yes, please list names, side effects, and steps to avoid negative interactions between medications) ☐ No				
	1. Name of medication Side effects: Steps to avoid negative interactions:		3. Name of medication Side effects: Steps to avoid negative interactions:		
	2. Name of medication Side effects: Steps to avoid negative interactions:		4. Name of medication Side effects: Steps to avoid negative interactions:		

EXHIBIT Descriptor Code: ACBD-E7

RECORD OF MEDICATION

USE A SEPARATE FORM FOR EACH MEDICATION

End of Yellowstone Exhibit ACBD-E7

STUDENT'S NAME:	
DOB:	
MEDICATION:	

DIRECTIONS: Use your initials to document when you provided medication or a code from below to indicate why medication was not provided.

Date	Time	Dose	Route	Code	Notes

Eligible and Authorized School Medication Providers: Signature/Initials

S:	I:
S:	I:
S:	I:
S:	I:

CODES

(A) Absent
(ED) Early Dismissal
(F) Field Trip or Activity Off-Campus
(N) No medication available*
(R) Refused*
(S) Self-Administered**
(X) No School

*Contact student's parent/guardian as soon as possible.
**Ensure student has self-administration authority