2025-26 SCHOOL YEAR MEDICATION LOG
DO NOT DESTROY *Entries are Computerized*

SCHOOL: Mountain Shadows

Student Name:

DOB:

Teacher: Room No:

Grade:

Diagnosis:

Medication:

Dosage:

Frequency:

Daily PRN (Circle)

Physician's Name Tel. No.

Prescription #

Medication Reconciliation:
Count_____ Date_____
Count_____ Date_____
Count_____ Date_____
Count_____ Date_____
Count_____ Date_____
Count_____ Date_____
Count_____ Date_____
/ initials

Comments:

A=Absent ■=Holiday/no school
▒=90 min Early Release
F=Field Trip #s=time given.
Initials=person administering Rx
X=Taken as directed
Blank=No Med. Given
B=Bottle sent home for refill
NMH-No med. Here
ER=Early Release

	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
				31	1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29
JULY AUG										▒					▒					▒					
	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30			
SEP	■									▒					▒					▒	■	■			
			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
OCT			■	■	■				ER K-12	ER K-12					▒					▒					▒
	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28					
NOV					▒		■			▒					▒	■	■	■	■	■					
	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31		
DEC					▒					▒				ER HS	ER K-12	■	■	■	■	■	■	■	■		
	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30					
JAN	Staff Dev. Day									▒	■				▒					▒					
	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27					
FEB					▒				ER K-8	ER K-8	■				▒					▒					
	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31			
MAR					▒					▒	■	■	■	■	■					▒					
			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	
APR					■															▒					
					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21						
MAY					▒					▒					▒				ER K-12						

Nurse's Signature & Title	Initials
Stacey Camp	SC
[illegible]	KCJ
[illegible]	PAP

Designee Signature & Title	Initials

Student Name:

Dose Time:

ER days: give/hold

DEER VALLEY UNIFIED SCHOOL DISTRICT # 97

PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I request that the school nurse or my agents (Principal/Designee) see that

_____receives this medication from _____ to
Student's Name Date

_____ at _____ for _____.
Date Time Reason for Medication

_____
Medication Dosage

This medication is furnished by me, and if it is prescription*, it is in its original pharmacy bottle, labeled with my child's name, prescription number, and identification of medication. If it is an over-the-counter medication, it is to be in its original container. The date, time given, and amount given should be entered above. School district personnel will not be responsible or liable for any reaction to medicines given according to the above direction. All medication will be kept in a locked cabinet in the nurse's office and dispensed from there. I understand it is my responsibility to monitor medication supply and provide additional medication when needed.

*If the medication is a sample given by the physician, please provide a signed note from the physician telling who the medication is for, the date, and instructions for giving the medication.

I understand that my child may receive medication administered by a nursing student, under the direct supervision of the school's nurse, and give my consent for this.
Please initial one: Yes_____ No_____

Other medications currently taken by my child:_____

_____

_____ _____
PARENT'S SIGNATURE DATE SIGNED

_____ _____
TEACHER GRADE

Contact Email:_____

3/2023

For Office Use: Doctor Order Received _____
Date

Medication Brought to School

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

DATE_____AMT_____SIGNATURES_____/_____

EARLY RELEASE DAYS

I request my student **RECEIVE / DOES NOT RECEIVE** medication at School on early release days. (circle appropriate answer)

Parent Signature _____

END OF YEAR MEDICATION DISPOSITION

AT THE END OF THE NEED OR THE END OF THE SCHOOL YEAR:**

Please initial one of these statements:

_____ I WILL PICK UP MY STUDENT'S REMAINING MEDICATION.
_____ PLEASE DESTROY ANY REMAINING MEDICATIONS.

**DISCONTINUED MEDICATIONS WILL BE RETAINED FOR THREE DAYS, THEN DESTROYED. MEDICATIONS NOT PICKED UP WITHIN ONE DAY OF THE END OF SCHOOL YEAR WILL BE DESTROYED.

Date picked up _____ Signature_____
Date meds destroyed_____
Amount picked up _____