Descriptor Code: ACBD-E5

RECORDS OF CONTROLLED MEDICATION

USE A SEPARATE FORM FOR EACH MEDICATION

This form will be sent to the Central Office at the completeion of the school year

STUDENT NAME ______________ DOB ________ SCHOOL YEAR ________ SCHOOL ____________ GRADE ________

MEDICATION ______________ DOSE ________ TIME ________

FROM ______________ TO ______________ EMERGENCY MEDICATION ______________

See "Authorizations/Parental consent for medication administration" attached to this form for instruction and reference.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															

AB=Absent RE=Refused NS=No School DC=Discountinued CH=Changed HO=Holiday FT= Field Trip OOM- Out of Medication

Initials	Name:	Initials:	Name:	Initials:	Name:	Initials:	Name:

*See Febuary - June on back

Date of medication check in	Amount Checked in and in Container	Staff Initials	Guardian Initials	Guardian Name - Print

Date	Comment

Descriptor Code: ACBD-E5

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Initials	Name:	Initials:	Name:	Initials:	Name:	Initials:	Name:

Date of medication check in	Amount Checked in and in Container	Staff Initials	Guardian Initials	Guardian Name - Print

Date	Comment