

2026-27 SCHOOL YEAR MEDICATION LOG

SCHOOL: _____

DO NOT DESTROY *Entries are Computerized*

Student Name:	AUG	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				
DOB:		3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31								
Teacher: Room #:	SEPT		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30						
Grade:	OCT				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30				
												Half K-12	Half K-12	■	■	■	■	■												
Diagnosis:	NOV	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30								
Medication:	DEC		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31					
Dosage:	JAN	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29									
Frequency: Daily PRN (Circle)	FEB	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26									
Doctor Name:	MAR																													
Prescription #:	APR				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30				
Medication Reconciliation:	MAY	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25												
Count _____ Date _____ Initials _____																	Student Name:					SCHOOL PHOTO								
Count _____ Date _____ Initials _____																	Dose Time:													
Count _____ Date _____ Initial _____																	Early Release									Give/Hold (circle)				
Count _____ Date _____ Initials _____																	Half Day									Give/Hold (circle)				
Comments:																														
A=Absent ■=Holiday/no school ■=90 min Early Release F=Field Trip #s=time given. Initials=person administering Rx Blank=No Med. Given B=Bottle sent home for refill NMH-No med. Here ER=Early Release	Nurse Signature & Title				Initials				Designee Signature & Title				Initials																	

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: _____

3/2026 jd

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 _____