St. Joseph Catholic School

Westphalia, MO

Medication Authorization Form/Daily Log

Note: This form is needed for both over the counter and prescription medications. Complete one form for <u>each</u> medication.

I request the nurse or designated school staff member to give:

Name of Student: _____ Sex: ____ DOB: _____ Grade/Home Room (or Teacher): _____

Name of Medication: _____ Pharmacy: _____ Phone: _____

Dosage and Times: _____ Date From: _____ to: _____

For Treatment of: _____ Prescribing Physician: _____ Phone: _____

Phone Numbers: Mother/Guardian: (Home) _____ (Work) _____ (Cell) _____
Father/Guardian: (Home) _____ (Work) _____ Cell) _____
Parent/Guardian Signature: _____ Date: _____

PLEASE RETURN THIS FORM WITH THE PROPERLY LABELED MEDICATION IN THE ORIGINAL CONTAINER. THE PHARMACIST WILL PROVIDE AN EXTRA CONTAINER FOR SCHOOL.

<u>Office Use Only:</u>

Directions: Record time of administration and initial. A complete signature and initial of each person administrating medications should be included below.

	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
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															

Note: Person administering medication should initial and sign below.

CODES: **(A)** Absent **(O)** No Show **(E)** Early Dismissal **(W)** Dosage Withheld **(F)** Field Trip **(X)** No School (i.e. holiday, weekend, snow day. etc.) **(N)** No Medication Available

Initial____Signature _____ Initial _____Signature _____ Initial ____ Signature _____

Use reverse side for reporting significant information (e.g. observations of medication's effectiveness, adverse reactions, reason for omission, plan to prevent future "no shows".)