CARROLL COUNTY PUBLIC SCHOOLS MEDICATION FORM

(PLEASE PRINT)

Name: _____ Allergies: _____ Grade/Teacher: _____

Medication: _____ Strength: _____ Dosage: _____ Time: _____

From: _____ To: _____ Reason: _____ Side Effects: _____

If medication administration is necessary during school hours, this form must be completed before any representative of the school can administer prescription or non-prescription medications to your child. **Special Notes:**

1. Medications must be in original container and marked specifically for student.

2. All homeopathic / herbal, prescription AND non-prescription medicines require a parent AND physician or nurse practitioner signature. (Physician's Assistant signature NOT acceptable) *EXCLUSION: Ibuprofen and Acetaminophen in age appropriate doses only.

3. Medications are not to be transported by students. This is in violation of our Drug-Alcohol policy. Leftover medication will be returned to parent, guardian or designated adult. Unused, unclaimed, or expired medicines will be destroyed at the end of the school year.

I therefore authorize and request representatives of Carroll County Public Schools to administer the medication listed above, in doing so, relieve them of ill effects resulting from the administration of medication to my child.

Parent/Guardian Signature: _____ Physician Signature: _____ Physician's Phone # _____

Inhaler Release: (It is the student's responsibility to report usage to the school nurse) (Minimal age for student to carry inhaler is 7 yrs.)

This section must be completed in addition to above for those students who request permission to carry their own inhaler.

We acknowledge that the student named above has been instructed as to the proper use, understands the purpose and the appropriate method as well as the frequency of use of their inhaler. We request that the student may be able to carry their inhaler on their person or secured in their locker.

Parent/Guardian Signature: _____ **Physician Signature:** _____

Codes (chart reason)

A - Absent
C - School Closed
E - Early Dismissal
F - Field Trip
H - Holiday
L - Late Opening
N - None Available
O - No Show
W - Dose Withheld

Initial	Name	Initial	Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MONTH	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																															
SEPTEMBE																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

MEDICATION COUNT

DATE	MEDICATION	STRENGTH	REC'D	COUNT	TOTAL	INT

Initial	Name	Initial	Name
______	______________	______	______________
______	______________	______	______________

NURSING NOTES

DATE	COMMENTS