CABELL COUNTY PUBLIC SCHOOLS
MEDICATION ADMINISTRATION –MEDICATION LOG
(One Medication Per Form)

Student_____ **MEDICATION / DOSAGE**_____

School_____Year_____ **TIME / METHOD OF ADMINISTRATION**_____

D.O.B._____Teacher_____Gr._____ **ALLERGIES**_____

Parent Signature_____ **DIAGNOSIS**_____

Parent PH (Hm)_____(Wk)_____(Cell)_____ **INTENDED EFFECT OF MEDICATION**_____

PHYSICIAN_____**PH**_____ **SIDE EFFECTS**_____

(Please Print)
PHYSICIAN SIGNATURE_____**DATE**_____ **OTHER MEDICATIONS TAKEN**_____

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																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															
JULY																															

INITIAL NAME

_____ _____

_____ _____

_____ _____

CHART REASON (If not given):

--: Weekend H: Holiday S: Snow/weather related day off

D: Early Dismissal A: Absent W: Dose Withheld (notify nurse 1st)

N: No Meds O: No Show C: Comment (see reverse side)

REVISED 4/14

PLEASE DOCUMENT AMOUNT OF MEDICATIONS RECEIVED ON REVERSE SHEET