Student Picture Here

_____
Name of School

School Year: 2022-2023 Month: MAY 2023

Name of Student: _____ Date of Birth: _____ Sex: ____Grade: _____
Allergies: _____Name and Dose of Medication: _____
Route _____ Times given at School: _____Possible Side Effects: _____
Classroom Teacher when medication is due:_____ _____
Health Care Provider Name/Number: _____
Emergency Contact Names/Numbers: _____

Directions: Initial administration or use codes below. A complete signature and initials of each person administering 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**			

Authorized Person(s) administering or counting Medication:

Signature	**Initials**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Documentation Codes:

(A) Absent (R) Refused* (W) Dosage withheld*
(E) Early Dismissal (F) Field Trip (X) No School
(N) No medication available* (S) Self-administered

***Documentation required in student's health file and Parent/Guardian to be contacted. Please notify teachers if medication withheld for any reason. Documentation of medication count is on the back.**

MEDICATION TRACKER

DATE	**MEDICATION**	**AMOUNT IN & BY WHOM**	**AMOUNT OUT & BY WHOM**	**QUANTITY/TOTAL** ***(At School)***