

Student Picture
Here

Name of School

School Year: 2023-2024

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
Aug	-	-	-	-	X	X	-	-	-	-	-	X	X	-					X	X						X	X				
Sept		X	X	X					X	X						X	X						X	X						X	-
Oct	X	X	X	X	X	X	X	X						X	X						X	X						X	X		
Nov				X	X	X	X				X	X						X	X			X	X	X	X	X					-
Dec		X	X						X	X						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Jan	X					X	X						X	X	X					X	X						X	X			
Feb			X	X						X	X						X	X						X	X					-	-
Mar		X	X						X	X						X	X						X	X						X	X
Apr	X	X	X	X	X	X	X						X	X						X	X						X	X			-
May				X	X						X	X							X	X						X	X				
June	X	X						X	X						X	X							X	X					X	X	-

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 of this MAR**