Student name	❑ Male ❑ Female	Home address	Student ID#	
	Date of birth			
Grade/Class	Teacher	School		Photo
Parent/Guardian name	Parent/Guardian emergency contact numbers (include all)			

Best Safe Practice: ❑ (Triple check) right student, right medication, right dose, right time, right route (compare with Medication Administration Order/MAR)
❑ Medication in original container/prescription bottle

Medication name:	Begin date:	End date (if known):	Discontinued order date:
Medication dosage:	Possible adverse reactions:		
Medication time:	Special instructions:		

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																															

Nurse/staff signature	Initials

X = No school
AB = Absent
ER = Error
O = No medication available
F = Field trip
H = Hold

Medication Count

Medication name	Arrival date	Initial count

Parents/Guardian: All Medications will be disposed of a week after school is dismissed for the year unless a parent or guardian picks the medication up.

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Parent Signature ___________________________

Parent Permission: I release & agree to hold the Board of Education, its officials, & its employees harmless from any & all liability for dames or injury resulting directly or indirectly from this authorization. I understand that the

Knox County Career Center

Authorization for School Personnel Monitoring

Prescription and Over the Counter Medication

Parent/Guardian Section: Please review the following steps required for school personnel to monitor the administration of medication by your child and then sign this section.

1. No medication will be dispensed to a student without a written request signed by both a physician or licensed prescriber and a parent/guardian,
2. Medication must be provided in the student's labeled prescription bottle. If it is an over the counter medication, it be in the original container. The prescription/container label must match the instructions from the prescriber.
3. Any revision of the medication requires a new form.
4. Medication form must be renewed each school year.
5. Unless otherwise indicated, students are expected to report for their medication. I request that medication be taken by my child according to the directions of the licensed prescriber in the following section. I authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary.
6. Any medication left after school is dismissed must be picked up by a parent/guardian. It will be disposed of a week after school is dismissed for the year.

Student's Name ______________________________ Date of Birth ____________

Address ______________________________ Grade ________

Phone # ____________ Emergency # ____________ Lab Teacher ____________

Signature or Parent/Guardian ______________________________

Licensed Prescriber Section: By signing below, I verify that the listed medication is to be taken by the above named student. I understand it will be monitored by authorized school personnel.

This is: New Medication __________ Revision __________

Date Start ______________________ Date End ______________

Name of Medication ______________________ Dosage ______________ Time ____________

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Special Instructions: (Storage, Sterile Conditions, etc.) ______________________________

____

Licensed Prescriber's signature: (No Stamp) Date:

______________________________ ______________

Licensed Prescriber's printed name: Phone Number:

______________________________ ______________

Licensed Prescriber's Address:

____