Frontier School Corporation Medication Log

20___-20___ School Year

☐ Scheduled Medication ☐ As needed Medication

Student Name____ Grade:______ Age: ____________

Drug Name:____________________________ Dose:____

Time to be administered:_____________________ Additional Instructions:______________________

____

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Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30	30	30	30	30
31	31	31	31	31	31	31	31	31	31

Frontier School Corporation

Medical Forms: Consent for Medication Administration at School

NOTE: Each child MUST have a separate form.

I request that the nurse or designated staff member be permitted to give my child the following medication(s):

Name of Child:____

Frontier Elementary _____ Frontier High School _____

Age: ____ Weight: _____ Grade: _____ Teacher: ________________________________

Medication Allergies:_______________________________ No Known Medication Allergies: ____

1) Name of Medication: (Drug name and Dosage)____
   - How much? (ex. 1-2 tablets or 1 tsp) ____________________________________
   - How often? (ex. Every 3-4 hours) ______________________________________
   - When? (ex. As needed or daily) _______________________________________
   - Why? (ex. For headache or pain) _______________________________________
   - How long? ____ Specific number of days. How many days? _________________
   - ____ Until the end of school year

2) Name of Medication: (Drug name and Dosage)____
   - How much? (ex. 1-2 tablets or 1 tsp) ____________________________________
   - How often? (ex. Every 3-4 hours) ______________________________________
   - When? (ex. As needed or daily) _______________________________________
   - Why? (ex. For headache or pain) _______________________________________
   - How long? ____ Specific number of days. How many days? _________________
   - ____ Until the end of school year

The medication(s) will be furnished by me (the parent or guardian) in the original bottle or box , including the current prescription label on the container. Prescribed medications should include physician information. Over-the-counter medications must also be labeled with the student name.

I do personally and on behalf of my named child hereby release the school, the staff of the school and the school corporation from any and all liability for any damage arising from the administration of medication in accordance with my instructions and do hereby waive and give up any claim that I or my child might have resulting there from.

______________________	X______________________
Date	Signature of Parent/Guardian
______________________	______________________
Physician's Name	Printed Name of Parent/Guardian
______________________	______________________
Physician's Phone Number	Parent/Guardian Phone Number

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A Parent signature below will allow us to send your child's medications home at the end of the year. If we are unable to send the medication home we will need to make arrangements for you to pick the medication up or it will be destroyed at the end of the year.

______________	X______________________
Date	Signature of Parent/Guardian