Ortonville Public School
ADMINISTERING MEDICATION IN SCHOOL

It is not the responsibility of the school or its employees to prescribe drugs, medications or home remedies. Medications should be administered at home under the supervision of the parent/guardian when possible. However, some students require administration of medications to be performed during the regular school day. In those situations, the following procedure will be followed:

Parent/Guardian Needs to Bring the Medication to School

Physician Order for Medication and Parent/Guardian Authorization

Before any prescription medication will dispensed by school staff, a Physician Order for Medication and Parent/Guardian Authorization form must be signed by the parent/guardian of the student and must be on file with the school nurse. The forms are available from the nurse or on the school website.

Prescription Medications

Prescription medications must be provided in an original pharmacy container with a current label. Prescription medications brought to school in any other container will not be administered. Questions regarding dosage and administration of the medications will be directed to the prescribing physician or the parent/guardian, at the discretion of the school staff. Medications will be administered after questions have been resolved.

Over-the-Counter Medications

Parent/guardian must complete and sign an Authorization of Administration of Over the Counter Medication form before school staff will administer over-the-counter preparations. Over-the-counter medications, other than Tylenol, ibuprofen, Benadryl, cough drops, cortisone cream, Neosporin, and Tums, must be provided in the original labeled container. These are the medications that are usually available in the nurse's office. Over-the-counter medications will only be administered to a student according to the label directions, unless written directions from a physician are provided.

Physician Authorization for Self-Administration of Medication

For prescriptions or over-the-counter medications that are carried by the student for self-administration, a **Physician Authorization for Self-Administration of Medication** form must be completed by the physician and signed by the parent/guardian.

Sharing of Medications Prohibited

Students may not share prescription or over-the-counter medications with other students. Appropriate disciplinary action may be taken if necessary, upon the determination by the principal or his/her designee, after investigation that a violation of this policy has taken place.

Unused Medications

When use of a medication has ceased, or is no longer needed by the student, it is the parent/guardian's responsibility to retrieve unused medications from the school. Any unused medications will be disposed of by the school upon the written request of the parent/guardian or at the end of the school year.

Ortonville Public School

PRESCRIPTION MEDICATION FORM

PHYSICIAN ORDER FOR MEDICATION AND PARENT/GUARDIAN AUTHORIZATION FORM
(TO BE RENEWED ANNUALLY)

Student _____ Date of Birth _____

Parent/Guardian _____ Teacher/Grade _____

PHYSICIAN'S ORDER

I hereby request and authorize you to administer to the above-named student:

	MEDICATION	DOSAGE	TIME	DURATION
1.				
2.				
3.				

Diagnosis/Medical reason for medicine: _____

Other medications this student is taking: _____

Allergies: _____

Other recommendations/unusual side effects: _____

Physician's signature _____ Date _____

Print physician's name _____ Phone No. _____

C1inic _____ Fax No. _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this student's physician.
2. I will immediately notify the school of any change in the medication or physician's order, dosage change, frequency, or duration of administration.
3. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
4. I give permission for the school nurse to consult with this child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
5. I release all school personnel and the Ortonville Public Schools from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
6. The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. **It** may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.
7. Field Trips:

   a) I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

   b) I release all school personnel, the Ortonville Public Schools, and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

_____ PhoneNo. _____(Cell)
(**Parent/Guardian Signature & date**) _____ (W)

Ortonville Public School
OVER-THE-COUNTER MEDICATION
AUTHORIZATION OF ADMINISTRATION OF MEDICATION

Student_____DOB_____

Parent/Guardian_____Grade/Teacher_____

I hereby request and authorize you to administer to _____ (Student)

_____ (check here) for permission to give medications available in the nurse's office such as Tylenol, ibuprofen, Tums, Benadryl, cortisone lotion, Neosporin

Name of Medication not available at school _____

Dosage_____

_____

Allergies _____

Time (or Frequency)_____

Reason for Use_____

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.

I release school personnel from the liability in the event any reaction results from the administration of this medication.

---Phone No. (c)_____
Parent/Guardian Signature

Phone No. (w)_____

PARENT/GUARDIAN: The procedure for administering medication on a field trip is different from medication administration during the regular school day.

Procedure for students who may need to take medication while away from school on a field trip is as follows:

It is the teacher's responsibility to inform, in advance, the Health Office when the class is going on a field trip. Any medication that needs to be given to the student will be sent with the teacher/responsible adult who will carry and administer the medication on the field trip as necessary.

When the teacher/responsible adult administering the medication on the field trip returns to the school building, he/she must record the time and sign the medication administration recording sheet in the medication book.

I give permission for the teacher/responsible adult on a field trip to give my child_____ his/her medication that has been set up by the Health Office. (Name)

I release school personnel from liability in the event of any reaction which results from the administration of this medication.

Medication Occurrence /Error Report

Student Name: _____ DOB:_____

Time and date of Occurrence: _____ **Location of Occurrence:** Health Room Class Room

Off Site ____Other: _____

Staff lnvolved: _____ LSN/RN _____ Health Assistant ____Teacher ____Substitute Office Staff ____
Medication Name/Dose: _____
Response Observed: No Adverse Minor Adverse Effect ____Major Adverse Effect

Describe Adverse Effect_____

Student Condition Prior to

1. Alert/Normal
2. Agitated
3. Unconscious
4. Refuses to cooperate
5. Depressed affect
6. Suicidal affect
7. Lethargic
8. Substance Abuse Suspected
9. Intoxicated
10. Language Barrier
11. Other (please indicate): _____

Medication Variance: Medication Dose:_____
Variance:_____

1. Medication Missing
2. Adverse side effects
3. Medication given but not charted
4. Medication charted but not given
5. Duplication/Extra Dose given
6. Time Variance(> I hour)
7. Wrong Route
8. Wrong Dose
9. Wrong Student

Procedural Variance: Explain:

1. Performed on Wrong Student:
2. Improper Identification of Student
3. Student was Not On Time
4. Staff not on time
5. Omission of Medication
6. Medication not available
7. Permission not signed
8. Security problem
9. Equipment not available/operating

Name/Title of Person Responsible for Occurrence: _____

Parent/Guardian Called: _____ Date & Time: _____

Parent/Guardian Response _____

Doctor Called: Date: _____ Time: _____ Arrived: _____ Notification Only: _____

911 Called: Time: _____

Response: _____

School Administrator Called: Time: _____ LSN/RN Called: Time: _____

Other: _____

Report Completed by _____ Date _____

Reviewed By _____ Date _____

Adapted from "Medication Use In Schools, " Philip E. Johnson MS, RPh, FASHP, et. af., Florida Society ofHea!th-System Pharnwcists, 2003 Florida edition.

Parent/Legal Guardian Health & Emergency Permission Slip for Field Trips

_____has my permission to attend

(Student Name)

_____ at _____

(Activity)

on _____.

I give my permission for my son/daughter to receive the medications listed below and treatment of an injury by any physician or hospital designated by a school official, List any medication your child is *allergic to* under the Allergies section of this form.

PLEASE LIST ANY MEDICATION YOUR CHILD NEEDS TO TAKE WITH HIM/HER ON THE FIELD TRIP.

Allergies:_____

_____

Medications for the Field Trip:

Medication: _____
Dose: _____
Route: _____
Time of Administration: _____

Medication: _____
Dose: _____
Route: _____

Time of Administration: _____

_____ / / _____

Signature of Parent/Legal Guardian *Date* *Emergency Telephone Number*

Adapted from Washington Department of Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools, June 8, 2001.

Field Trip Medication Administration Procedure

The following procedures are for staff of ISD 2903 to meet the medication needs of students on field trips/school sponsored activities. The staff person/volunteer accompanying the student during the field trip will be responsible for security of the medication, medication administration, and documentation.

SCHOOL HEALTH PERSONNEL RESPONSIBILITIES:

1. Communicate and work with teachers of students requiring medication on field trip.
2. Place correct number of medication dosages for the field trip in the labeled medication envelope after checking the six rights:
   a. Right Student
   b. Right Medication
   c. Right Dosage
   d. Right Time
   e. Right Route (oral, inhaled, drops, injection)
   f. Right Document

Insert the bottle with original label and/or label an envelope with student's name, medication name, dosage, route and time to be given.

School Envelope
No.: _____ Date: _____
For: _____
Directions:
_____

3. Copy the authorization for administration of medication and student medication record form and place in labeled plastic bag, along with the medication envelope.

4. Document the medication dose prepared for the field trip in the comments section of the student medication record.

5. Ensure that the school district person signs the student medication record to acknowledge receipt of the medication on the day of the field trip.

6. Upon their return, ensure that medication administrator (school or school health person) returns the original bottle and envelope and records the dose administered on the student medication record.

SCHOOL DISTRICT PERSONNEL RESPONSIBILITIES:

I. Teacher will notify the school health staff of a scheduled field trip 24 hours in advance.

2. Receive the medication in a properly labeled medication envelope from the LSN/RN or Responsible School Health Authority, and acknowledge receipt of the medication with their signature on the student medication record. (Morning of the Field trip).

.

3. Keep the medication in a secure place at all time while on the field trip.

4. Administer the medication within 60 minutes before or after the time indicated on the authorization for administration of medication form.

5. Return the authorization for administration of medication form to the health room 24 hours following the field trip. Sign your name, and indicate the time the medication was administered, on the student medication record.

PARENT/STUDENT RESPONSIBILITIES:

After School-day Field Trips:

I. Parents should be notified two weeks in advance of a field trip in order to coordinate with their physician in obtaining the authorization for all medications needed on a 24-hour basis.

2. Bring in the original medication bottle(s) from home, which addresses all regularly scheduled medications**.**

3. Return the school permission form(s) along with the appropriate medical information for medical emergencies, and the authorization for administration of medication form.

4. Meet with school personnel to discuss the medical needs of the student and the arrangements for the medication administration.

ADDITIONAL INFORMATION:

- If a liquid medication is to be dispensed, the original container and a device for measuring the medication must be taken on the trip.

- Non-prescription medications must be in the original bottle and have a manufacturer's label with directions for age-specific doses, along with the appropriate authorization for administration of medication form.

- If a medication is not given as it is ordered, the person responsible for overseeing the medication administration on the field trip must complete a medication omission/error report, available from the school health office.

Adapted from "Medication Use In Schools, " Philip E. Johnson A1SRPh, FASHP, et. a/., Florida Society of Health S..vstenf2 Pharmacists, 2003 Florida edition.

Field Trip Medication Administration Training & Skills Check List

If school staff is to give the medication, the following training and skills check off is necessary prior to the field trip experience.

	Date/Comments	
A. Knows policy on medication:		
1. All medications (prescription and over-the-counter) need a signed authorization form from the parent/legal guardian and/or licensed prescriber.		
2. Medications are to be in properly labeled bottles or the original container or as provided by the school nurse.		
3. Medications are to be kept in a secure area. (car trunk, school bus cargo space or fanny pack.) Caution should be given to storage of medication in areas with temperature extremes.		
4. Only designated and trained school staff may give medications.		
B. Procedure		
1. Copy of parent/legal guardian and/or licensed prescriber authorization form to accompany medication.		
2. Familiarize self with information on order form.		
3. Check side effects and what to do if problems occur.		
4. Check label on bottle (is to be the same as on the form).		
a. Name of medication		
b. Name of student.		
c. Dosage		
d. Route		
e. Time to give		
5. Count and record the number of pills in the bottle or container or record the amount of medication *(not in pill form)* with another school staff before the field trip and after you return to school.		

Adapted from Washington Department -of' Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools·, .June 8, 2001.

C. How to administer medication.		
1. Check:		
a. Right student (ask student his/her name).		
b. Right medication.		
c. Right time (to give the medication).		
d. Ask if student has already received the medication.		
e. Prepare medication-based on route of administration.		
f. Watch and observe the student for completion of the administration process.		
g. Close and return medication to proper storage.		
h. Record that the medication was given on the log.		
i. If medication was wasted or destroyed, have a witness co-sign with you and give the reason.		
j. Any questions regarding medication, page or call school nurse, parent, school health designee, and/or licensed prescriber as set forth in school district policy and procedure.		

_____ _____

School Staff Person/Trainee/Volunteer Signature *Date*

_____ _____

Name and Credentials of Trainer *Date*

Adapted from Washington Department of Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools, June 8, 2001.

Emergency Information Form for Children With Special Needs

Last name:

Name:

Birth date:

Nickname:

Home Address:

Home/Work Phone:

Parent/Guardian:

Emergency Contact Names & Relationship:

Signature/Consent*:

Primary Language:

Phone Number(s):

Physicians:

Primary care physician:

Emergency Phone:

Fax:

Current Specialty physician:
Specialty:

Emergency Phone:

Fax:

Current Specialty physician:
Specialty:

Emergency Phone:

Fax:

Anticipated Primary ED:

Pharmacy:

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1 .

Baseline physical findings:

2.

3.

Baseline vital signs:

4.

Synopsis:

Baseline neurological status:

*Consent for release of this form to health care providers

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1.

2.

3.

4.

5.

6.

Significant baseline ancillary findings (lab, x-ray, EGG):

Prostheses/Appliances/Advanced Technology Devices:

Management Data:

Allergies: Medications/Foods to be avoided and why:

1.

2.

3.

Procedures to be avoided and why:

1.

2.

3.

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: Print Name:

Self-Administration of Medication Authorizations

Parent/Legal Guardian's Request and Authorization for Self Carry/Self- Administration

I, request and authorize my child _____ to carry and/or self-administer

their medication _____ ***(Circle one or both options)***
(insert name of medication).

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger himself/herself or other persons, and will not misuse the medication.
- I understand that if my child misuses by not taking the prescribed dosage, or endangers other with the medication, school employees or agents may confiscate the medication.
- Understand that this authorization shall be effective for this current school year and must be renewed annually.

_____
Parent/Legal Guardian Name (PLEASE PRINT)

_____ __/__/__
Parent/Legal Guardian Signature *Date*

Physician's Licensed Prescriber's Authorization to Self Carry/Self Administer

I, certify that _____has a medical condition and/or potentially
(Student's name)
threatening illness _____and this student is capable
(Specify illness or condition)
of and has been given instruction in the proper method of self-administration of

_____
(Name of Medication)

_____
Licensed Prescriber/Physician's Name (PLEASE PRINT)

_____ __/__/__
Licensed Prescriber/Physician's Signature *Date*

_____ _____
Address *Phone*

School Acknowledgement and Notification that _____
(Student's name)
will be self carrying/self-administering his/her medication(s).

Reviewed and accepted by _____
Licensed School Nurse/Registered Nurse *Date*
Or Responsible School Health Authority

Self Carried / Self Administered Medication Agreement & Evaluation Form

Student _____ Grade/Program_____

Physician/Licensed Prescriber_____

Telephone_____

Medication_____ Dose _____ Time _____

Medication is permitted in accordance with district policy and procedure. In addition to the parent/legal guardian, the student's licensed prescriber/physician must authorize self-carried/administered medication. Student name must appear on the medication container, inhaler or injector.

Responsibilities for carrying medication

The student's self-carry plan is in place and complete
The student can demonstrate correct use/administration
The student recognizes proper and prescribed timing for medication
The student agrees to not share medication with others
The student will keeps the medication in an agreed upon location(s) *(please indicate location)*_____
The student will keep a second labeled container in the health office *(optional)*
The student agrees to come directly to the health office if having the following symptoms after using medication:

_____

The student (is) (is not) able to demonstrate the specified responsibilities.
The student may carry the medication unless and until he/she fails to follow the above agreement.
Yes No
Comments and added responsibilities

_____
_____
_____
_____
(LSN/RN signature and date)

_____.agrees with the above requirements: Yes No

_____
(Student signature and date)

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and a new plan will be developed.

_____ _____
(Parent/legal guardian signature and date) *(Parent daytime telephone number(s)*

Adapted from "Manual for Training of Public School Employees in Administration of Medication," Virginia Department of Education, Division of Instruction, Office of Special Education and Student Services, 2000.

Authorization To Carry
Self-Administration of Medication
PRECRIPTION/OTC/CAMS
FRONT OF CARD

Student:

Medication-:_ _

Individual Health Care Plan on file: Yes or No
Student Agrees to School Policy &/or contract in place: Yes or No
Date: Not Valid After:
Health (LSN/RN) Signature:
Student Signature:

BACK OF CARD

Adapted from "Medication Use In Schools, '' Philip E. Johnson MS, RPh, FASHP, et. a/., Florida Society of Health-System Pharmacists, 2003 Florida edition.

Medication Administration Skills Check List

	Date Skill was Verbalized/Demonstrated
A. Knows policy on medications.	
1. All medications (prescription and over the counter) need a parent/legal guardian and/or licensed prescriber s i g n e d request form before medications are given. Verbal authorization needs to be reduced to writing in two davs.	
2. Medications are to be in prescription bottle or original container.	
3. Medications are stored in locked drawer, cabinet or refrigerator.	
4.Only designated and trained staff members or school nurses mav give medications at school.	
5. Medication administration records will be maintained on each student receiving medications at school.	
6. The health office has a medication folder which contains the following:	
a. Parent and/or Licensed Prescriber authorization forms.	
b. Medication administration record.	
c. District medication administration procedure.	
d. List of trained staff able to administer medication copy of this skills check list).	

B. Knows and follows procedure as for how medication is received	
1. Familiarize self with the medication that each student is taking	
2. Check possible side effects for each medication (list on form).	
3. Check label on bottle (same as on form),	
a. Name of Student	
b. Dosage and time to give	
4. Transfer student's medication information on medication administration form	
5. Count and note the number and amount of medication, record and date	

C. How to administer medications.	
I. Wash hands.	
2. Check medication record form for:	
a. Student's name.	
b. Name of medication,	

c. Dosage unit and amount of medication to give.	
d. Route by which the medication is to be taken	
e. Time to give medication	
f. Check to see if medication has already been given	
3.Check label on medication to correspond to medication	
a. Student's name.	
b. Name of medication.	
c. Dose of medication and amount of medication to be given.	
d. Route medication is to be given.	
e. Time to give medication.	
f. If information on record does not match medication container:	
1. Call registered nurse or the school's responsible health authority.	
2. Parent may give medication until situation is resolved.	
4. Handle medication appropriately whether pills, liquid, drops, ointment, or injection. (Does not touch medication with hands)	
5. Give student medication. Check label.	
a. Assist as necessary. Observe student to assure medication is administered without problems.	
6. Replace medication and place in locked cabinet, drawer or refrigerator out of the reach/access of others.	
7. Record medicine given on medication record in appropriate date space, sign and/or initial.	
8. A new parent/legal guardian and/or licensed prescriber authorization(s) are needed before any changes in medication can be administered at school. If changes are requested immediately, call the registered nurse or responsible health authority	
9. Discontinuance of medication can be done any time by the parent, either verbally or in writing.	
10. Any problems or concerns should be communicated to parent, registered nurse and/or the school's responsible health authority.	

Staff person/trainee _____

Date_____

Name of trainer & credentials_____

Verbal Medication Consent Form

(Use this form if a parent legal/guardian is requesting medication be given but has not presented a written authorization. Only valid for two days.)

Date of request_____

Student Name_____

Date of Birth_____

Parent/Legal Guardian _____

_____

Telephone (home)_____ (work)._____

Licensed Prescriber _____ Telephone _____
Address _____

Verbal instructions (to be followed in two days in writing)

Date Given	*Medication*	*Dose*	*Time Given*	Signature

(After two days of medication, there should be written authorization.)

_____

(Signature of person taking the verbal request, as directed in school district policy and procedure)

Adapted from Washington Department of Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools, June 8, 2001.

Receipt for Medication

School _____ Student's Name _____

Medication _____ Dosage _____

Type of Medication	tablets or capsules	liquid	ointment
	rectal medication	inhaler	drops
	injection		

_____

Signature of school staff accepting medication

_____

Person delivering medication

Provide: one copy for the student file and one copy for the parent/legal guardian

Adapted from Washington Department of Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools, June 8, 2001.

Student Medication Count Log

Licensed School Nurse/Registered Nurse_____

Other designate school staff dispensing medications_____

Student Name	Date Meds Rec'd	Medication and dose/unit	Amount
Count/Date | Count/Date | Count/Date | Count/Date | Count/Date		Count/Date | Count/Date | Count/Date | Count/Date | Count/Date	

Student Name	Date Meds Rec'd	Medication and dose/unit	Amount
Count/Date _| Count/Date | Count/Date / Count/Date / Count/Date		Count/Date | Count/Date / Count/Date / Count/Date_/ Count/Date	

Student Name	Date Meds Rec'd	Medication and dose/unit	Amount
Count/Date | Count/Date | Count/Date | Count/Date | Count/Date		Count/Date | Count/Date | Count/Date | Count/Date | Count/Date	

Student Name	Date Meds Rec'd	Medication and dose/unit	Amount
Count/Date | Count/Date | Count/Date | Count/Date | Count/Date		Count/Date | Count/Date | Count/Date | Count/Date | Count/Date	

Student Name	Date Meds Rec'd	Medication and dose/unit	Amount
Count/Date | Count/Date | Count/Date | Count/Date | Cmmt/Date		Count/Date | Count/Date Count/Date | Cmmt!Date \ Count/Dat e	

Student Name	Date Meds Rec'd	Medication and dose/unit	Amount
Count/Date | Count/Date | Count/Date | Count/Date | Count/Date		Count/Date | Count/Date | Count/Date | Count/Date | Count/Date	

Adapted from Washington Department of Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools, June 8, 2001.

Left over Medications Parent Letter

Date _____ Student Name _____

Re: Medication Returned

Dear Parent/Legal Guardian;

We are making plans to close out this school year. This includes seeing that the medication your child has left will get home in a safe manner. Please make arrangements to pick up the medication at school. Any medication left in the building after the last day of school *will* be destroyed.

If your child needs to take this prescription medication during the school hours next school year, please have your health care provider complete the attached form before school starts in the fall. We will also need your authorization to administer medications as well. Bring the completed medication authorizations and the medication in a properly labeled container to the nurse's office when school begins in the fall.

Thank you for your cooperation.

Licensed School Nurse

Adapted from Washington Department of Public Instruction, Bulletin No 34-01 Learning and Teaching Support, Re: Medication Administration in the Schools, June 8, 2001.

Sample form

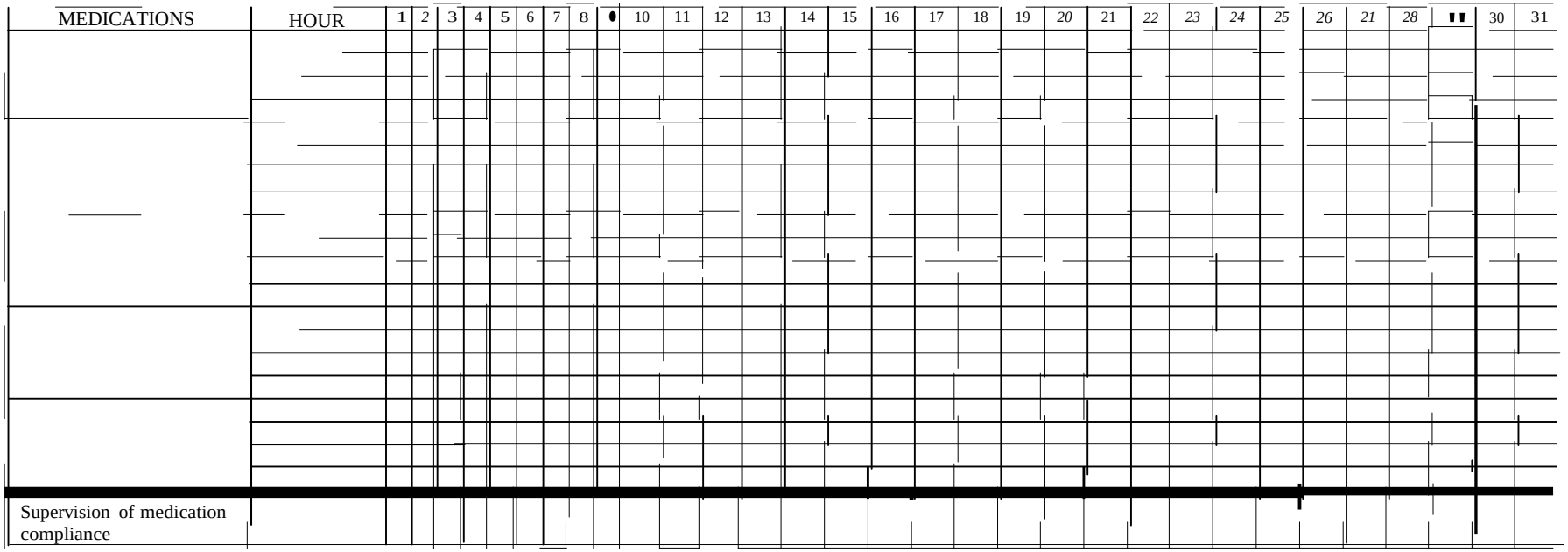
Medication Administration Record

School _____

Student Name: _____ DOB: __/__/__ **Prescriber:**----------

For any unusual circumstance, circle your initials and write a comment on the back of the sheet.
Be sure to include the date, the time, and the medication(s) involved.

Month: _____



Recording Codes:

(A) Absent; (O) No Show; (E) Early Dismissal; (W) Dosage Withheld; (F) Field Trip;
(X) No School (e.g., holiday, snow day); (N) No Medication Available

Adapted from "Assisted Living Home Care Manual for Provider An Educational Tool. Minnesota Department of Health, July 1999.

STAFF NAME AND TITLE

STAFF NAME AND TITLE

INITIALS

Special Remarks
(Be sure to Sign Your Entry)

DATE	TIME	MEDICATION!S)	

Student Name:

Room#:

Adapted from "Assisted Living Home Care Manual for Provider An Educational Tool, Minnesota Department of Health, July 1999.