

Harding

A C A D E M Y

Parental Authorization / Daily Log for Self-Administration of Medication

(Parent / legal guardian should complete one form per student for each medication)

Student _____ Teacher *(elementary only)* _____ Grade _____

Name and Dosage of Medication _____ Route (i.e. oral, topical) _____

Frequency _____ Time(s) To Be Given in School _____

Discontinuation Date _____ Possible Known Side Effects _____

Is the student able to self-administer this medication with assistance? yes no Purpose of Medication _____

Signature of Parent/Legal Guardian _____ Daytime Telephone _____ Date _____

AREA BELOW THIS LINE FOR SCHOOL USE ONLY

	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																															
SEPT																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUNE																															
JUL																															

This form becomes a part of the student's permanent record.

Initials/Signatures of persons assisting the student in self-administration of medication:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Codes

- (A) Absent
- (E) Early Dismissal
- (X) No School
- (F) Field Trip
- (W) Dosage Withheld
- (N) No Medication Available

Use reverse side for reporting significant information.

