Medication Documentation Record (MDR)

Student name	❑ Male ❑ Female Date of birth	Home address	Student ID#	Photo
Grade/Class	Teacher	School		
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																															

Medication Count

Nurse/staff signature	Initials

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

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.

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 medication must be kept in its original container.

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 _____

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

_____

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

_____ _____

Licensed Prescriber's printed name: Phone Number:

_____ _____

Licensed Prescriber's Address:

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