School Year: 2026-2027 **MEDICATION RECORD** Order good for up to the end of one school year

School: **The Franklin School of Innovation** Prescription or Non-prescription Medication Expiration Date: _____

PHYSICIAN AUTHORIZATION *(To be completed by the Physician)* **Student:** _____ **DOB:** _____

Name of Medication: _____ Dosage/Route _____ Time: _____ or for PRN, every _____ hours.

Reason medication is prescribed: _____ Start date: _____ Stop Date: _____

Significant information/Parameters for Administration/Instructions/Contraindications: _____

Licensed Health Care Provider Signature: _____ **Date**: _____ **Phone**: _____ **Fax:** _____

DAILY MEDICATION LOG

	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.																															
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Name Initials Name Initials Nurse Date