# THE PROPERTY AND A STATE OF THE PARTY AND A ST

# **School Medication Record I**

School '	Year: <b>J</b> u	ıl 1, 20	24 - I	Dec 3	1, 2024																		Dat	e:				
Student	's Name	:												Birth Da	te:			Ger	nder:			Gra	ide:		Room:			
Medicat	ion:						Sche	dule II		Strengtl	1:		Dos	age:		Route:			Time	Schedule:			Dose Fo	rm:		Color:		
1ST WEEK 2							ND WEI	ī.K			3RD WEEK						4TH WE	FK		_	5TH WEEK							
	M	Т		W	TH	F	7	M	T	W	TH	F	M	T	W	TH	F	M	Т	W	TH	F	M	Т	W	TH	F	
Jul	01	02	_	03	04	05		08	09	10	11	12	15	16	17	18	19	22	23		25	26	29	30	31			
	Ш	Ш								ш	oxed	Ш		Ш				Ш				$oxed{oxed}$			Ш			
Aug			_		01	02	2	05	06	07	08	09	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30	
Sep	02	03		04	05	00	6	09	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30					
Oct		01		02	03	04	4	07	08	09	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31		
	Ш	Ш								Ш	oxed	Ш		Ш		Ш		Ш				Ш			Ш			
Nov		<b>_</b>		_		01	1	04	05	06	07	08	11	12	13	14	15	18	19	20	21	22	25	26	27	28	29	
Das	02	03		04	05	00	6	09	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31				
Dec	02	03		U4	05	00	U	Uy	10	11	12	13	10	1/	19	19	20	23	24	45	20	21	30	31				
																											Ш	

## Los Angeles Unified School District Medical Services Division



# **School Medication Record I**

School Year: Jul	1 1, 2024 - Dec 31, 202											Date:						
Student's Name:					Birth			Birth Date:			nder:	Grade:		Room:				
Medication:		Sc	chedule II	J	Strength:	Do			Route:		Time Schedule:			se Form:	Co	olor:		
Special Instruction	ons or Adverse Effects:																	
Date Started:	1	Date Discor	ntinued (If ap	plicabl	e):	Name of	Teacher N	Notified:				Dat	e notifie	ed:				
Parent's Name:							Phones	Home		Wo	ork		Ce	Cell				
Health Care Prov	vider's Name:				Address:				City:			Zip Code:		Phone:				
Medication order	transcribed by:				Date:	Date: Revi			ol Nurse:					Date:				
Print Name:		Signat	ture:	A	UTHORIZE	ED SIC	SNA'	TURES Print Na		n &		nature:			In	itial:		
Print Name: Signature:							Print Name:			Sig	nature:			In	itial:			
Print Name: Signature:					Initial:		Print Na	me:	Sig	nature:		In	itial:					
DATE				RE								SIGNA	ΓURE					
2. For Sched	me administered & ir dule II drugs, indicate ant when refill of Scho	e count af	fter each do	se a	dministration in the					nent se	ection.	l		8.00 SN	1.00 SN			
														Drug C	ount:			

# **School Medication Record II**

School '	Year: <b>Ja</b> ı	n 1, 2025	5 - Jun	30, 202	25																	Da	e:						
Student	's Name:												Birth Da	te:			Ge	ender:			Gra	de:		Room					
Medicat	ion:					Schedul	le II	J	Strength	1:		Do	sage:		Route:			Time	Schedule:			Dose Fo	orm:		Col	or:			
1ST WEEK 2N										ND WEEK 3RD WEEK									4TH WE	БИ		5TH WEEK							
		T	W W	TH	I F	-	M	T	WEE	TH	F	M	T	W	TH	F	M	Т	_	TH	F	M	T	W		Ή	F		
Jan	141	1	01	02		_	06	07	08	09	10	13	14	15	16	17	20	21	_	23	24	27	28	29	_	30	31		
- Oun									00			10			10	7			7		<u> </u>				T				
																				Ш									
	Ш																			$\sqcup \sqcup$									
Feb	03	04	05	06	07	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28								
Mar	03	04	05	06	07	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31							
Apr		01	02	03	04	ı ı	07	08	09	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30					
	Ш										ш									ш					$\perp$				
May					02	2	05	06	07	08	09	12	13	14	15	16	19	20	21	22	23	26	27	28	2	29	30		
																Ш				Ш									
	62							10		10	12	1.	1.5	10	10		22	1	- 25		25	20				Ш			
Jun	02	03	04	05	00		09	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30		-	_				
						-1																							

## Los Angeles Unified School District Medical Services Division



# **School Medication Record II**

chool Year: Jan 1, 2025 - Jun	30, 2025								D	Date:						
tudent's Name:					Birth Date:		Ge	nder:	Gra	ade:	Room:					
Medication:	Schedule II	Ţ	Strength: D		Dosage:	Route:	ute: Time		·	Dose Form:			Color:			
pecial Instructions or Adverse E	ffects:															
Date Started:	Date Discontinued (If app	plicable	e):	Name of	Γeacher Notified:				Date no	Date notified:						
arent's Name:				Parent's	Phones: Home		W	ork		Cell	11					
Health Care Provider's Name:			Address:			City:		Zip	Code:							
Medication order transcribed by:			Date:		Reviewed by	School Nurse:				D	Date:					
N. A.	G:	A	UTHORIZ			ES (Print, Si	gn &						T 1/2 1			
Print Name:	Signature:			Initial:	Pri	nt Name:		Signatu	re:				Initial:			
Print Name:			Initial:	Pri	nt Name:		Signatu	re:				Initial:				
Print Name:	Signature:			Initial:	Pri	nt Name:		Signatu	re:				Initial:			
DATE			R	EMARKS							SIGNAT	URE				
2. For Schedule II drugs, i	red & initial in the appropria ndicate count after each do of Schedule II drugs is rec'	se ad	lministration in th				ment s	section.			8.00 SN	S	00 N			