Health Services Department
200 E 800 S, Heber City, UT 84032
Email: health.services@wasatch.edu
Phone: (435) 654-0280 x4144
Fax: (435) 200-1032

Student Medication Count Log

Student Name: _____

Medication Name: _____ Dose: _____

*********Counts MUST be completed anytime a medication is brought into the school, leaves the school, or changes control from one person to another. If a discrepancy occurs in the count, all adults must stay present until the building administrator and RN on-call have arrived and released all parties involved.*

Nurse Call Phone: (435) 395-8219

Date	Time	Count	Does this match the Medication Administration Log? **(Y/N)**	Signature/Title of person **counting**	Signature/Title of person **witnessing**

WASATCH COUNTY SCHOOL DISTRICT

DAILY MEDICATION ADMINISTRATION SHEET

SIS ID: _____ Date: _____

Students Photo

Student Name: _____ Birth Date: _____ Address: _____

Parent Name: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____ Email: _____

School: _____ Grade: _____ Year: _____ Teacher: _____

Medication: _____ **Dose:** _____ **Route:** _____ **Time:** _____ **Medication use for**: _____

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 Codes: Student Absent (A) No Show (NO) Late (L) Field Trip (FT) Medication Out (MO) Expired Med. (E)

Signature of those AUTHORIZED TO ADMINISTER MEDICATION	Initial	Signature of School Nurse verifying that person has been trained TO ADMINISTER MEDICATION	Initial	Date

MEDICATION DATE/NAME/AMOUNT BROUGHT IN/INITIAL OR PERSON AND EXPIRATION DATE

DATE	NAME OF MEDICATION	Amount Received	Expiration Date	School Staff Signature	Parent Signature

Medication Name	Date Discarded	How Discarded	Two Signatures	

NO FLUSHING MEDICATION DOWN SEWER