Howards Grove School District

As Needed Daily Medication Log

Name_____ Grade_____ Teacher/HR_____

Medication_____ Dosage_____ Frequency/Time _____

Route _____ Symptoms to use for _____ Begin Date _____ End Date _____

Date	Time	Dosage	Symptoms	Initials	Date	Time	Dosage	Symptoms	Initials

Authorized Personnel	
Initials	**Signature**

OTC Medication ONLY

Date	Dropoff (+) or Pickup (-)	Amount	Initials

Parent/Guardian Telephone Number:

Howards Grove School District

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Medication_____ Dosage_____ Frequency/Time _____

Route _____ Symptoms to use for _____ Begin Date _____ End Date _____

Date	Time	Dosage	Symptoms	Initials	Date	Time	Dosage	Symptoms	Initials