Los Angeles Unified School District
Office of the Chief Medical Director

Office of the Chief Medical Director | LAUSD UNIFIED

School Medication Record I

School Year: **Jul 1, 2024 - Dec 31, 2024**						Date:
Student's Name:		Birth Date:	Gender:	Grade:	Room:	Track:
Medication:	Schedule II ☐	Dosage:	Route:	Time Schedule:	Dose Form:	Color:

	1ST WEEK					2ND WEEK					3RD WEEK					4TH WEEK					5TH WEEK				
	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F
Jul	**01**	**02**	**03**	**04**	**05**	**08**	**09**	**10**	**11**	**12**	**15**	**16**	**17**	**18**	**19**	**22**	**23**	**24**	**25**	**26**	**29**	**30**	**31**		
Aug				**01**	**02**	**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**	**06**	**09**	**10**	**11**	**12**	**13**	**16**	**17**	**18**	**19**	**20**	**23**	**24**	**25**	**26**	**27**	**30**				
Oct		**01**	**02**	**03**	**04**	**07**	**08**	**09**	**10**	**11**	**14**	**15**	**16**	**17**	**18**	**21**	**22**	**23**	**24**	**25**	**28**	**29**	**30**	**31**	
Nov					**01**	**04**	**05**	**06**	**07**	**08**	**11**	**12**	**13**	**14**	**15**	**18**	**19**	**20**	**21**	**22**	**25**	**26**	**27**	**28**	**29**
Dec	**02**	**03**	**04**	**05**	**06**	**09**	**10**	**11**	**12**	**13**	**16**	**17**	**18**	**19**	**20**	**23**	**24**	**25**	**26**	**27**	**30**	**31**			

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Medication:	Schedule II ☐	Dosage:	Route:	Time Schedule:	Dose Form:	Color:

Special Instructions or Adverse Effects:				
Date Started:	Date Discontinued (If applicable):	Name of Teacher Notified:		Date notified:
Parent's Name:		Parent's Phones Home	Work	Cell
Health Care Provider's Name:	Address:	City:	Zip Code:	Phone:
Medication order transcribed by:	Date:	Reviewed by School Nurse:		Date:

AUTHORIZED SIGNATURES (Print, Sign & Initial)

Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:
Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:
Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:

DATE	REMARKS	SIGNATURE

Instructions:

1. Indicate time administered & initial in the appropriate box.
2. For Schedule II drugs, indicate count after each dose administration in the lower box; ie: Ritalin & Dexedrine.
3. Circle count when refill of Schedule II drugs is rec'd in the lower box; also chart # of additional doses rec'd in the comment section.

8.00 SN	1.00 SN

Drug Count:

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School Medication Record II

School Year: **Jan 1, 2025 - Jun 30, 2025**						Date:
Student's Name:		Birth Date:	Gender:	Grade:	Room:	Track:
Medication:	Schedule II ☐	Dosage:	Route:	Time Schedule:	Dose Form:	Color:

	1ST WEEK					2ND WEEK					3RD WEEK					4TH WEEK					5TH WEEK				
	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F
Jan			01	02	03	06	07	08	09	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31
Feb	03	04	05	06	07	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28					
Mar	03	04	05	06	07	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28	31				
Apr		01	02	03	04	07	08	09	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30		
May					02	05	06	07	08	09	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30
Jun	02	03	04	05	06	09	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30				

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Health Care Provider's Name:	Address:	City:	Zip Code:	Phone:	
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Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:
Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:

DATE	REMARKS	SIGNATURE

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