School LCS MEDICA Student Name / Grade				THOREGO AGO DEGEORG EGIS			d. Exp. Date Allergies		
lame of Medication					Reason for Med	lication / Diagnosi	S		
Dosage (total mg to be given) Time(s) to be given				Amount (e.g. #o	f pills to be given	_Route (e.g. by mouth) Medicaid #			
Week	*(1) Refills/F.T. Count Date/Initials	*(2) Weekly Count Date/Initials	Monday Time/Initials	Tuesday Time/Initials	Wednesday Time/Initials	* 5 minutes of scheo Thursday Time/Initials	duled nursing time for ea Friday Time/Initials	ch (1) & (2) completed Medicaid Weekly Signature	
8/13/18 - 08/17/18									
8/20/18 -08/24/18									
8/27/18 - 08/31/18									
9/03/18 - 09/07/18			Holiday						
9/10/18 - 09/14/18									
9/17/18 - 09/21/18									
9/24/18 - 09/28/18									
0/01/18 - 10/05/18									
0/08/18 - 10/12/18							Holiday		
0/15/18 - 10/19/18									
0/22/18 - 10/26/18									
0/29/18 – 11/02/18									
1/05/18 - 11/09/18									
1/12/18 - 11/16/18			Holiday						
1/19/18 - 11/23/18			Holiday	Holiday	Holiday	Holiday	Holiday		
1/26/18 - 11/30/18									
2/03/18 - 12/07/18									
2/10/18 - 12/14/18									
2/17/18 - 12/21/18					E.R.	E.R.	E.R.		

LCS MEDICATION CONTACT/REFILL LOG

Last Name, First Name

Date	Time	Type of Contact**	Amount of Refill	Amount Picked Up/Returned	Comments	Parent/Guardian Signature	Teacher Signature	Nurse/SHA Signature, Title

**Use Codes	Ι.,	Face '	to :	tace
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2. Telephone contact with guardian made Contact Made By: (Signature, Title/ Print Name/ Initials)

3. Left message

4. No contact made