Exhibit **Form ACBD-E4**

STUDENT MEDICATION RECORD

SCHOOL YEAR 2024-2025

NAME: _____ DOB: _____ GRADE/TEACHER: _____

MEDICATION: _____ DOSE: _____ ROUTE: _____ TIME: _____ START DATE: _____ END DATE: _____

	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUG																															
SEPT		NO SCH-OOL																												NO SCH-OOL	
OCT																	NO SCH-OOL	NO SCH-OOL												
NOV	NO SCH-OOL										NO SCH-OOL																NO SCH-OOL	NO SCH-OOL	NO SCH-OOL		
DEC																									X-mas						
JAN	New years day																			No sch-ool											
FEB																	No Sch-ool														
MAR										No Sch-ool																					
APR																	No Sch-ool	Good Friday			No Sch-ool										
MAY																															

MEDICATION CODES (DOCUMENT IN RED: COMMENT ON BACK)

AB: Absent **RE**: Refused **NS**: No Show **NM**: No Meds **FT**: Field Trip **W**: Withheld Dose

Initials	Signature/Title	Initials	Signature/Title	Initial	Signature/Title
_____	_____	_____	_____	_____	_____
Initials	Signature/Title	Initials	Signature/Title	Initial	Signature/Title
_____	_____	_____	_____	_____	_____

STUDENT MEDICATION RECORD
SCHOOL YEAR 2024-2025

Date/Time	On Hand	Received	Returned	Total	Verifying Signature #1	Verifying Signature #2

Date	Comments