COLUMBUS COUNTY SCHOOLS - MEDICATION COMPLIANCE AUDIT TOOL

Student___________________________ DOB_________ School____________________ Year_________

Teacher___________________________ Grade______ Medication________________________________

Staff Person(s) Administering Medication____

Retention of completed audit tools: File by school year and store permanently at school of origin

Complete This Section For Initial Medication Review And Medication Changes

DATE											
Medication logged-in correctly on Medication Check-In Log Form											
Medication authorization form completed by Health Care Provider and signed by parent/guardian											
Individual Medication Administration Record complete and correct											
Medication label and authorization form in agreement											
Date on Medication container checked/Date of expiration											
Medication in secure location											
Medication and authorization form located together											

Routine Medications

DATE											
Initials and signature lines completed by each person giving meds(bottom of sheet)											
All boxes filled with initials, time, or appropriate code											

PRN, Emergency Medication Administration Record completed correctly											
Student Agreement for Self-Carried Medication completed											

NOTES

School Nurse Signature____________________________ **Initials**_________