EXHIBIT Descriptor Code: ACBD-E7

RECORD OF MEDICATION

USE A SEPARATE FORM FOR EACH MEDICATION

<table>
<tr><td rowspan="6">STUDENT'S PICTURE</td><td>STUDENT'S NAME</td><td colspan="4"></td></tr>
<tr><td>DATE OF BIRTH</td><td colspan="4"></td></tr>
<tr><td>SEX</td><td colspan="4">☐ Male ☐ Female ☐Transgender</td></tr>
<tr><td>GRADE</td><td colspan="4"></td></tr>
<tr><td rowspan="4">NAMES AND LOCATION OF STUDENT'S TEACHERS BY PERIOD</td><td>1st</td><td></td><td>5th</td><td></td></tr>
<tr><td>2nd</td><td></td><td>6th</td><td></td></tr>
<tr><td>3rd</td><td></td><td>7th</td><td></td></tr>
<tr><td>4th</td><td></td><td>8th</td><td></td></tr>
<tr><td>HEALTHCARE PROVIDER PHONE NUMBER(S)</td><td colspan="3">Name:
Name of Practice:
Phone Number:</td><td colspan="2">Name:
Name of Practice:
Phone Number:</td></tr>
<tr><td>PARENT/GUARDIAN EMERGENCY CONTACT NUMBER</td><td colspan="3">Name:
Relationship to student:
Phone number:</td><td colspan="2">Alternative contact:
Relationship to student:
Phone number:</td></tr>
<tr><td>LIST ALL KNOWN ALLERGIES</td><td colspan="5"></td></tr>
<tr><td>NAME OF MEDICATION PROVIDED AND POSSIBLE SIDE EFFECTS (Use a separate form for each medication)</td><td colspan="5">Name of Medication:

Side effects:</td></tr>
<tr><td>IS DISPENSING EQUIPMENT REQUIRED?</td><td colspan="5">☐ Yes (If yes, please list below with any storage instructions) ☐ No</td></tr>
<tr><td rowspan="3">IS STUDENT TAKING MEDICATIONS OTHER THAN LISTED ABOVE?</td><td colspan="5">☐Yes (If yes, please list names, side effects, and steps to avoid negative interactions between medications) ☐ No</td></tr>
<tr><td colspan="3">1. Name of medication
Side effects:
Steps to avoid negative interactions:</td><td colspan="2">3. Name of medication
Side effects:
Steps to avoid negative interactions:</td></tr>
<tr><td colspan="3">2. Name of medication
Side effects:
Steps to avoid negative interactions:</td><td colspan="2">4. Name of medication
Side effects:
Steps to avoid negative interactions:</td></tr>
</table>

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RECORD OF MEDICATION

USE A SEPARATE FORM FOR EACH MEDICATION

STUDENT'S NAME:	
DOB:	
MEDICATION:	

DIRECTIONS: Use your initials to document when you provided medication or a code from below to indicate why medication was not provided.

Date	Time	Dose	Route	Code	Notes

Eligible and Authorized School Medication Providers: Signature/Initials

S:	I:
S:	I:
S:	I:
S:	I:

CODES

(A) Absent
(ED) Early Dismissal
(F) Field Trip or Activity Off-Campus
(N) No medication available*
(R) Refused*
(S) Self-Administered**
(X) No School

*Contact student's parent/guardian as soon as possible.
**Ensure student has self-administration authority

End of McClusky School District #19 Exhibit ACBD-E7