Medication Compliance Audit Tool

School_____ **Date**_____

Completed by_____

Student Initials	Drug/ Dose/Freq./Duration (List each med separately)	Authorization Form (current year)		Photo	Rx. Labeled properly	Meds secure?	Exp. date	Date & count of brought to school	Tracking Form	
		Health	Parent						Drug, dose, Time	Codes, Initials, signature

A copy of the audit will be given to:

Notes	Date sent	
		School Staff :
		School Principal :
		School Director :
		School Risk Manager :
		Health Dept. Administration :
		Medication Book :