Germantown Municipal Schools

Medication Variance Report Form

(Follow outlined Variance Reporting Procedure)

School name: _____ year: _____

Student name:. _____ DOB:. _____ .Sex: ___ Grade:. _____

Student home address _____ Home Phone: _____

Parent name: _____ Work phone:. _____

Name of licensed prescriber:. _____ Phone: _____

Address: _____ City: _____ Zip: _____

Name of medication: _____ Date of parent authorization: _____

Reason medication is prescribed: _____ Scheduled time of administration: ____

Dose Prescribed: _____ Route of administration: _____

Date and time variance occurred:. _____

Explain the variance: (attach and fax additional sheets as needed- indicate# of pgs. see above right)

_____

_____

_____

_____

_____

_____

Variance notification chain: (completed by School Nurse/School Staff- check all that apply)

School nurse: ____ School Administrator: ____ Licensed prescriber: ____ Parent/Guardian notified: _____

Coordinated School Health: _____ Other persons notified: _____

Action taken by: _____ Date and time:: _____

Principal signature: _____ Date: _____

Signature of person completing report: _____ Date &Time of report: _____

CSH Follow up: _____

_____

Signature: _____ Date:. _____