DIRECTLY OBSERVED THERAPY LOG

DIRECTLY OBSERVED THERAPY FOR THE MONTH OF:

STUDENT'S NAME:

DATE OF BIRTH:

SCHOOL:

GRADE:

ROOM NUMBER:

DIAGNOSIS:

MEDICATION:

PRESCRIBING PHYSICIAN:

PHONE:

DATE TREATMENT STARTED:

DATE TREATMENT ENDED:

				SIDE EFFECTS*	PATIENT COMPLAINTS											
CIRCLE DAYS OF THE WEEK	DATE/ TIME	INITIALS OF PERSON ADMINISTERING MEDICATION	COMMENTS	* If present, check appropriate box and write disposition under comments. If absent, check box for none.	Nausea	Vomiting	Abdominal Pain	Headache	Loss of Appetite	Jaundice/Yellow Color	Rash	Fatigue	Joint Pain	Flu-like Symptoms	Others	None
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SIGNATURES/INITIALS OF PERSON ADMINISTERING MEDICATION:

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CODES:
H: HOLIDAY A: ABSENT F: FIELD TRIP
S: SENT HOME SICK N: NONE AVAILABLE

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