STUDENT MEDICATION INFO

Please indicate when your child will need their meds below:

- ◯ AM
- ◯ MID DAY
- ◯ PM
- ◯ BED TIME
- ◯ AS NEEDED

Student Name: _____ **Date of Birth:** _____

Medication #1: _____ **Start Date:** _____

Dosage/Frequency: _____ **Time Taken:** _____

☐ **Prescription** ☐ **Over The Counter** **Purpose:** [redacted]

Medication #2: _____ **Start Date:** _____

Dosage/Frequency: _____ **Time Taken:** _____

☐ **Prescription** ☐ **Over The Counter** **Purpose:** [redacted]

Medication #3: _____ **Start Date:** _____

Dosage/Frequency: _____ **Time Taken:** _____

☐ **Prescription** ☐ **Over The Counter** **Purpose:** [redacted]