Student Medication form

Student's Name: _____ Age: _____

Parent's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Prescribing Doctor: _____ Phone: _____

Name of Medication:

1._____ Dosage/Time: _____

2._____ Dosage/Time:_____

3._____ Dosage/Time:_____

4._____ Dosage/Time:_____

Possible Side Effects: _____

Instructions in case a dosage is missed: _____

Any other important information we need to know:_____

_____

Dates and times for administration:

Date	Time	Time Administered	(by) Initials
_____	_____ am / pm	_____ am / pm	_____
_____	_____ am / pm	_____ am / pm	_____
_____	_____ am / pm	_____ am / pm	_____
_____	_____ am / pm	_____ am / pm	_____
_____	_____ am / pm	_____ am / pm	_____
_____	_____ am / pm	_____ am / pm	_____

Parent's Signature: _____ Date: _____