



Student Medication Form

My Student, _____, needs to take the following medications according to the schedule listed below:

Name of Medication	Dosage	Time to be Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional comments and information about your student and or his/her medication that Supervising Staff ought to know so that we can serve your student as best as we can.

I, _____, Parent/Guardian of, _____, do approve all of the above information as accurate for the treatment of the above named minor.

Parent/Guardian

Signature: _____ Date: _____

Print Name: _____

Home Phone: _____ Work/Cell Phone: _____