BTITTEN SCHOOL
AUGUST 2016-AUGUST 2017

STUDENT PRESCRIPTION MEDICATION INFORMATION DATA

Student's Name: ______________________________ **Date of Birth:** _____/_____/_____

Please list on this form **every prescription medication taken by your student at home or school** to allow us to provide comprehensive medical emergency treatment. If your child does not need medication, please check the box below.

☐ **My student takes no medications at home or during the school day.**

Example:

Name of Medication: Adderrall

Dosage: 10 **mg/Time Taken:** 7:00 [AM]/PM

1. Name of Medication: ____________________
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**

2. Name of Medication: ____________________
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**

3. Name of Medication: ____________________
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**

4. Name of Medication: ____________________
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**

5. Name of Medication: ____________________
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**
Dosage: _________ **mg/Time Taken:** _______ **AM/PM**

*** Please note: A new set of forms must be filled out each time a medication change occurs.**

______________________________ ____________________
Parent/Guardian Signature **Date**