BRITTEN SCHOOL
AUGUST 2020- AUGUST 2021

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: Adderall

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**