BRITTEN SCHOOL
AUGUST 2021- AUGUST 2022

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 <u>NO</u> 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**