Medication Schedule Form

Student Name: ____________________

Parent Name: ____________________

Parent Number: ____________________

Parent Signature: ____________________

Over the counter medications the student should NOT be allowed to take at the standard dose?

Medications provided and when they should be given

*if you want to provide the meds as needed just make "as needed"

Medication	Dose	Time of Day

Medication Record (to be used by Staff)

Medcation	Dose	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7