

Medication Schedule Form

Student Name:

Medications provided and when they should be given

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

Parent Name:

Medication

Dose

Time of Day

Parent Number:

Parent Signature:

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

Medication Record (to be used by Staff)

Medication

Day 1

Day 2

Day 3

Day 4

Day 5

Day 6

Day 7