For School Use Only

School _____ Month/Year: _____

(use new sheet for each month)

MEDICATION CHART

Student's Name: _____ Grade _____

Name of Medication: _____ Homeroom _____

Physician: _____

Pharmacy Name: _____ Pharmacy Phone Number _____

Reason for Medication: _____

Time(s) and Dosage given at: _____

Authorized by Parent/Guardian: _____

Special Instructions: _____

Medication Allergies: _____

Date	Time	Dosage	Initials	Date	Time	Dosage	Initials

Medication Sent to School:

Date	Amount	Check in by	Date	Amount	Check in by

Name & Initial _____ Name & Initial _____

Name & Initial _____ Name & Initial _____

Name & Initial _____ Name & Initial _____