Medication Schedule Form

Student Name: _____

Parent Name: _____

Parent Number: _____

Parent Signature: _____

REMINDER:

We will not provide any over-the-counter medication. If your student will use ***ANY*** medication, it must be in the original bottle.

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