

STUDENT MEDICATION INFO

This medication record must be completed:

- At the beginning of the year for each medication
- Each time there is a change in the medication (e.g. dosage, administration time or frequency)

This information is used to teach students to monitor their medical information.

Student Name _____	Date of Birth: _____
Student Phone: _____	Date of Update: _____
Primary Physician: _____	Phone: _____
Secondary Physician: _____	Phone: _____
Group and Policy Number: _____	

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR	REASON TAKEN

Any current allergies or medical concerns: