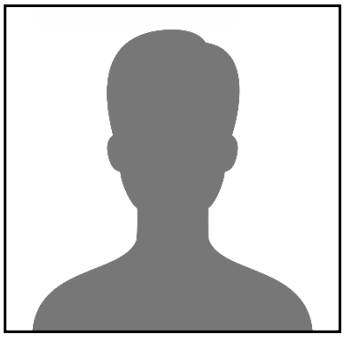
STUDENT MEDICATION FORM



Student Name: _____ Year Level: _____

Condition: _____

Name of Medication: _____

Duration of Administration: Ongoing or Dates Specified: _____

Method of Administering the Medication: _____

Prescribing Doctor: _____

Dosage	Time	Date	Administered By
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

PARENT/GUARDIAN INFORMATION

Requested by: _____ Date: _____

Relationship: _____ Contact Number: _____

Parent/Guardian Signature: _____

Unused medication to be returned to parent: YES / NO

ADMIN USE ONLY

TASS Input by: _____ Date: _____