

## LIST OF AUTHORIZED MEDICATIONS

Student Name: \_\_\_\_\_  
Last
First
Middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

If there are no medications, please indicate by initialing here: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list ALL medications the student is currently taking, including prescriptions and non-prescriptions:**

1. Medication Name: \_\_\_\_\_ mg per tablet *(if applicable)*

Dosage: \_\_\_\_\_ per \_\_\_\_\_

This medication is intended to treat: \_\_\_\_\_

2. Medication Name: \_\_\_\_\_ mg per tablet *(if applicable)*

Dosage: \_\_\_\_\_ per \_\_\_\_\_

This medication is intended to treat: \_\_\_\_\_

3. Medication Name: \_\_\_\_\_ mg per tablet *(if applicable)*

Dosage: \_\_\_\_\_ per \_\_\_\_\_

This medication is intended to treat: \_\_\_\_\_

4. Medication Name: \_\_\_\_\_ mg per tablet *(if applicable)*

Dosage: \_\_\_\_\_ per \_\_\_\_\_

This medication is intended to treat: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_