EPIC SCHOOL

*PLEASE COMPLETE ALL MEDS TAKEN DURING DAY/EVENING/NIGHT

(If your child does not take any meds please fill out top and sign)

Pupil Name: _____ Date of form: _____

ALLERGIES: _____

MEDICATION :

Recently Changed Name of Medication: _____
Dosage/frequency: _____

Date discontinued: _____ **or** Date of dosage change :_____

ALL CURRENT MEDICATION(S):

Medication	Dosage	Frequency

NEW MEDICATION INFORMATION ONLY

Medication: _____ Dosage: _____

Behavior(s) targeted: _____

Potential side effects of medication: _____

Follow up date: _____ Additional Comments: _____

Name of Prescribing Physician: _____

Address: _____ Phone: _____

Print Name of Person Completing Form	Signature	Date