MEDICATION DATA SHEET

STUDENT'S NAME: DATE:

Please **List ALL Medications**

Current Prescription Medication	Prescribing Healthcare provider	Pharmacy Used	Dosage and frequency of medication

Current Over The Counter Medications (including Herbal Supplements)

Please list any food or drug allergies	Provide reaction and required treatment

It is the student's responsibility to update this form as changes are made to medication(s) taken. Failure to provide this documentation could result in program dismissal. An original prescription or the medication dispenser may be requested for verification.

I have read and understand that I am responsible for reporting any and all changes in my medications/supplements and I will comply with the requirements stated above.

_____

Student Signature

_____

Student printed name

_____

Date