# STUDENT MEDICATION/PERSONAL CARE SCHEDULE

The following information will be used for the purpose of responding to the medical needs of your child.

Student Name:

Name of Medication/Personal care required:

Precaution(s) to be Taken:

Medication Schedule

| Date | Time | Medication Dosage/Care Provided | Monitored by (Signature) | Comments |
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***Note any physical changes in the student's presentation (i.e., unexplained marks or bruises, soreness, rash, etc.)**