☐ Please check here if this is an update to a previous medication list.
Date of update _____

Medication List

This information should include prescribed, over the counter medications that are taken on a regular basis, and supplements.

Student Name _____

Health Care Provider Name and Phone Number _____

Health Care Provider Signature _____ Date _____

*Note: An updated signature from the prescribing physician is required when a change to a prescription medication has been made.

Medication Name	Reason	Dose	Frequency	Times Administered			