Braham Area Schools
Non-Prescription
Medication Documentation

Student: _____ Grade/Teacher: _____ Year: _____
Medication: _____
Reason for medication: _____
Dose: _____ Time: _____ Allergies: _____
Additional instructions: _____
Parent/Guardian signature: _____ Date:_____

Date												
Time												
Dose												
Initial												

Date												
Time												
Dose												
Initial												

Date												
Time												
Dose												
Initial												

Date												
Time												
Dose												
Initial												

Date												
Time												
Dose												
Initial												