

**NORTHERN MICHIGAN UNIVERSITY
PARTICIPANT MEDICATION SCHEDULE AND INSTRUCTIONS**

ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER.

Child's Name _____ Doctor's Name _____

Name of Medication _____

First Dosage Time and Amount: _____

Second Dosage Time and Amount: _____

Days to Be Given: (please circle) Mon. Tues. Wed. Thu. Fri.

Name of Medication _____

First Dosage Time and Amount: _____

Second Dosage Time and Amount: _____

Days to Be Given: (please circle) Mon. Tues. Wed. Thu. Fri.

I give the Program Staff at NMU permission to administer the above medication at the times and date indicated to my child.

_____ Parent Signature

_____ Date

NMU Program Staff: Record medication/time given with your initials below:

Week of:	Monday	Tuesday	Wednesday	Thursday	Friday