

**POWERS CATHOLIC HIGH SCHOOL  
MEDICATION DOCUMENTATION**

**Student's Name** \_\_\_\_\_

**Academic Year** \_\_\_\_\_

**Parent/Caregiver** \_\_\_\_\_

**Non Prescription Medication**

**Prescription Medication**

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

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