BOX ELDER SCHOOL DISTRICT

*960 South Main * Brigham City, Utah * 84302*
*Phone: 435-734-4800 * Fax: 435-734-4833*

EFFECTS OF MEDICATION

Upon request this information will be shared with other professionals working with this student.

Student Name: _____ Grade/Teacher: _____ Date: _____

School: _____ Completed by: _____ Physician: _____

LIST NAME(S) OF MEDICATION(S) STUDENT IS TAKING:

Medication(s)	Dosage(s)	Time(s) of Day Taken	Dispensed By

******You must have a prescription on file for medication(s) given at school.******

For the weeks of _____ through _____ .

Note changes in behaviors: use "M" for "more", "L" for "less", and "S" for "same"

Behavior	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
on task										
completion of work										
impulsiveness										
talk outs										
organization, fine motor										
restlessness, fidgety										
talkativeness										
aggressiveness										

Mark any side effects noticed by you or mentioned by student:

Side Effects	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
loss of appetite										
insomnia										
headaches										
stomach aches										
tiredness										
stares a lot										
irritable										
vocal or motor tic										
sadness										
nervousness										