Form A
To Be Completed By Parent/Guardian

Name of Student _____

Name of medical condition(s) requiring medication to be given during school hours:_____

Note: Where possible parent(s)/guardian(s) are asked to establish a schedule for the administration of medication outside of the school day.

	Medication #1	Medication #2	Medication #3
Name of medication			
Brief Desrciption of Medication Ex: Heart Medication			
High Alert	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Required intervention	☐ **Administer by staff** ☐ **Self administer with staff monitoring**	☐ **Administer by staff** ☐ **Self administer with staff monitoring**	☐ **Administer by staff** ☐ **Self administer with staff monitoring**
Dose of Medication mg/ml/# tabs/amount			
Frequency			

Time(s) medication to be given during school hours			
Possible side effect(s) of medication			
Course of action in response to side effect(s)			
Route			
Special Handling of Medication			
Extra Comments			
Storage Requirements for medication			
Duration of treatment (start-finish dates)			
Date when medication first prescribed			
Symptoms of overdose and suggested course of action			

State course of action in the event a dose is missed			
For feeding tube medications only **The amount of water to be flushed through the feeding tube**	**Before med: _____ml** **After med: _____ml**	**Before med: _____ml** **After med: _____ml**	**Before med: _____ml** **After med: _____ml**

_____ _____

Parent/Guardian Signature Date

Appendix C
Form B
Administration of Prescribed Medication Record
To Be Completed Daily By School Personnel

Student Name _____

Medications to be Administered/Monitored by:

Name _____ Signature _____ Initials _____

Name _____ Signature _____ Initials _____

Name _____ Signature _____ Initials _____

Parent(s) / Guardian(s) names, home and emergency telephone numbers:

Name

_____

Home _____ Emergency _____

Name

_____

Home _____ Emergency _____

Name and telephone number of health care professional prescribing the medication:

Name _____ Telephone _____

Date	Medication	Time	Dose	Administered by (and witnessed where applicable):

	Comments