Form A

SECTION 2 – 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			
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			
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			

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