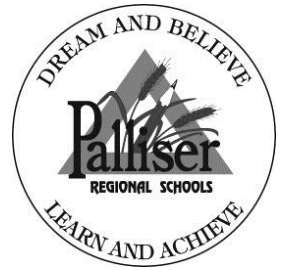


PALLISER REGIONAL SCHOOLS REQUEST FOR SCHOOL ASSISTANCE TO ADMINISTER MEDICATION



This plan is intended for physician-prescribed medications only.

STUDENT: _____

DATE OF BIRTH (YY/MM/DD): _____ Male Female

		Medication #1	Medication #2	Medication #3	Medication #4
COMPLETED BY PARENT		<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor
	Received medication in original container	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	Medication information sheets provided	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	Name of medication				
	Desired effect(s) of medication				
	Possible side effect(s) of medication				
	Plan of action in response to side effect(s) event				
	Dose of medication				
	Route of administration				
	Time(s) medication to be given at school				
	Start date of medication				
Finish or review date of medication					
COMPLETED DURING MEETING	Location of medication administration/ monitoring				
	Name of staff person to administer/ monitor medication				
	Name of alternative staff to administer/ monitor medication				
	Special instructions (please attach pharmacy printout)				

This serves to reinforce that persons administering medication in schools are not licensed medical personnel.

PARENT NAME: _____ SIGNATURE: _____ DATE: _____

SCHOOL STAFF NAME: _____ SIGNATURE: _____ DATE: _____

PRINCIPAL: _____ SIGNATURE: _____ DATE: _____