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
		□ Administer □ Monitor	□ Administer □ Monitor	□ Administer □ Monitor	□ Administer □ Monitor
	Received medication in original container	□ Yes	□ Yes	□ Yes	□ Yes
COMPLETED BY PARENT	Medication information sheets provided	□ Yes	□ Yes	□ Yes	□ 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: _____