

Appendix 1

## Administration of Medication Plan

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Student Medical Condition

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IS THIS A LIFE-THREATENING MEDICAL CONDITION OR ALLERGY? \_\_\_\_ YES \_\_\_\_ NO

**PARENTS/LEGAL GUARDIANS:** Please specify in detail the procedures to follow in the event that your child requires medical attention or medication. Please specify in detail and in the order of priority that you wish these instructions to be carried out, as these are your instruction to school staff:

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Contacts (in order of priority/times etc)

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Emergency

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**Type(s)of Medication Required:**

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**Dosage (amount, regime, administration procedures)**

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**Possible Side Effects e.g. hyperactivity, drowsiness etc.**

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**Medication will be transported or stored in the following manner:**

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**List of parties that need to be advised of Student's Conditions (i.e. bus company):**

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**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Administrator** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Signature (if required)** \_\_\_\_\_ **Date** \_\_\_\_\_

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