# STUDENT MEDICATION

Please complete this form if:

- Your child requires medication to be kept in the school office during the year for administration during school hours

**OR**

- There is a CHANGE TO MEDICATION OR HEALTH PLAN previously provided to the school

For administration of medication (e.g. antibiotics) for short periods please complete the ADMINISTRATION OF MEDICATION TO STUDENTS (Form 6) located on the school website under School Administration Notes.

<table>
<thead>
<tr>
<th>STUDENT NAME</th>
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<tbody>
<tr>
<td>CLASS</td>
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<tr>
<td>DATE</td>
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**INFORMATION PROVIDED BY**

Name _____________________________  
Signature _____________________________

**HEALTH PLAN**

Please provide outline of your child’s health plan

**MEDICATION**

Please list medication including expiry date  
All prescription medication must include the pharmacy label with the child’s name clearly marked

**Please attached health plan (if applicable):**

- Asthma Plan  Date of plan ______________
- Anaphylaxis Plan  Date of plan ______________
- Medical Plan other  Date of plan ______________