



Medication Administration Details

Student's Name: _____

DIAGNOSIS / REASON FOR MEDICATION:

MEDICATION DETAILS:

Medication(s) Prescribed	Dosage	Time to be Administered
1.		
2.		
3.		

Possible side effects (if any):

Duration of continuing medication(s):

Parent/Guardian Signature: _____ Date: _____

Notice of Collection

Information on this form is collected further to the board's authority under the Education Act. Information on this form will be used to administer medication as required in accordance with this schedule. Questions regarding the collection of this information should be directed to the Principal or privacy@innovoak.ca

Completed by:

Administrator of Medication

Distribution:

Attach to Medication Information Form 3004a

Retention:

1. OSR; 2. School Medical Emergency File (1 Year) 3. Medication Binder (Current Year)