WEST VANCOUVER SCHOOLS

Student Focused Medication Management Plan {Form 316-2)

Student Name (last/First):	
Date of Birth (day/month/year)	

This Plan is intended for Physician Prescribed Medications Only

	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**
Medication information sheets provided	**Yes**	**Yes**	**Yes**	**Yes**
Name of medication				
Additional notes related to the reason for administration of medication (e.g. allergies, etc.)				
Completed by •Parent:				
Desired effect(s) of medication				
Possible side effect(s) of medication				
Plan of action in response to side effect(s)				
Dose of medication				
Route of administration (i.e. by mouth)				
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)				

Parent/Guardian Name:	Staff Name:
Parent/Guardian Signature:	School Signature:
Date:	Date:

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Student Focused Medication Dispensing Record Sheet (Form 316-3)

Student Name (Last/First):	
Date of Birth (day/month/year)	

Current Date: (Month/Year): _____

Medication	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Date:	Comments:	Initials:

Administered/Monitored by:

Printed Name:	Signature:	Initials: