North Vancouver
School District
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ADMINISTRATIVE SERVICES
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Student Focused Medication Management Plan

Student Name (Last/First): ____________________

Date of Birth (d-m-y): ____________________

Grade: _____ Div./Homeroom: _____

This plan is intended for physician prescribed medications only.

		Medication #1 ☐ Administer ☐ Monitor	Medication #2 ☐ Administer ☐ Monitor	Medication #3 ☐ Administer ☐ Monitor	Medication #4 ☐ Administer ☐ Monitor
	Received medication in original container	☐ Yes	☐ Yes	☐ Yes	☐ Yes
	Medication Information sheets provided	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Completed By Parent	Name of medication				
	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: ____________________