



INDIVIDUAL PLAN OF CARE

Student Name: _____ Birth Date: _____

Name of Medication: _____ Dosage: _____

Reason for medication: _____

Method of Administration of medication: _____

When medication should be taken: _____

Minimum length of time between doses: _____ Expiration date of medication: _____

How should medication be stored? _____

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

I request and authorize this student to self-administer their medication. Yes ___ No ___

Possible side effects of medication: _____

NOTE: The medication must be kept in the original container, put in a Ziplock bag, and labeled with:

- The child's first and last name.
- The date the prescription was filled or medication purchased.
- The expiration date.
- Easy-to-read instructions on how to give the medication.

Medication information may be shared with school staff working with your child and 911 staff, if they are called.

Mother's Name (please print): _____

Telephone numbers: _____ (home) _____ (cell) _____ (work)

Father's Name (please print): _____

Telephone numbers: _____ (home) _____ (cell) _____ (work)

Parent signature: _____ Date: _____

Parent signature: _____ Date: _____