Skinner ELEMENTARY MONTESSORI

INDIVIDUAL PLAN OF CARE 2018-2019

This form MUST be completed. If there are no medications, please indicate "none". Thank you.

Child's name: _____

Name of medication: _____

Reason for medication: _____

Dosage: _____

How should medication be given? _____

_____

_____

_____

When should medication be given? _____

How often should the medication be given?_____

Expiration date of medication: _____

Side effects: _____

How should medication be stored? _____

Start date of medication _____ Stop date of medication _____

NOTE:
The medication must be kept in the original container, 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.

_____ _____
Parent signature Date

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