Rainbow District School Board

HEA-03

Individual Student Log of Oral Medication Administered

STUDENT INFORMATION

O.E.N. #: ______________________

NAME: ____ DATE OF BIRTH: ______________________

ADDRESS: ____ TELEPHONE #: _______________________

SCHOOL: ____ TEACHER: ___________________________

PHYSICIAN: ______________________________________ TELEPHONE #: _______________________

MEDICATION INFORMATION

Name and Prescription Number: ____

Dosage to be Administered: ____

Time to be Administered: ____

Name(s) of Person(s) to Administer Medication: ____

INDICATE ABNORMAL CIRCUMSTANCES BELOW

COMMENTS:

In accordance with Section 29(2) of the Municipal Freedom of Information and Protection of Privacy Act, personal information on this form is being collected under the authority of The Education Act and will be used for the purpose of providing emergency medical/hospital care and/or contacting the parent/guardian in the event of an emergency situation. Questions regarding this form should be directed to the principal.

Rainbow
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MEDICATION RECORD

Place initials in appropriate space to confirm that oral medication has been administered.

	SEPTEMBER		OCTOBER		NOVEMBER		DECEMBER		JANUARY		FEBRUARY		MARCH		APRIL		MAY		JUNE	
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