

SCHEDULED MEDICATION/TREATMENT RECORD

Child's Name: _____

To be completed by parent for **all** scheduled medications and treatments

One medication/treatment per form

Parent to review at month end

MEDICATION/TREATMENT/INFORMATION

Name: _____ Dosage: _____

Description: __Tablet __Capsule __Liquid __Spray __Other

Start Date: _____ End Date: _____ Storage Instructions: _____

Administration Instructions:

STOP the Medication/Treatment If:

I release **ZAREINU EDUCATIONAL CENTRE OF METROPOLITAN TORONTO** and its Employees from any liability, however caused, arising out of administering, or failure to administer, the medication provided herein.

Parent/Guardian Signature

Date

TIMES TO BE GIVEN: Month _____ Year _____

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

STAFF: INITIAL IN APPROPRIATE BOX WHEN MEDICATION HAS BEEN GIVEN

THIS RECORD IS TO BE RETAINED IN THE CHILD'S FILE

I authorize the administration of

_____ (medicine)

_____ (name of child)

By staff members (at least two)

1) _____

2) _____

Storage Instruction: _____

Additional Instructions: _____

Epi-Pens are not kept in a locked area to ensure easy access.

_____ (date)

_____ (Parent signature)

_____ (Principal's signature)

_____ (Parent signature)

_____ (Staff signature)

_____ (Staff signature)

THIS RECORD IS TO BE RETAINED IN THE CHILD'S FILE