



Individualized Plan for a Child with Medical Needs

Child's Name: _____ Date: _____

Grade: _____ Child's Medical Condition: _____

Symptoms & Warning Signs: _____

Course of Action: _____

Name of Medication: _____

Date Medication was Dispensed: _____ Medication Expiry Date: _____

Dosage and Frequency: _____

Medication Storage Instructions: _____

Possible Side Effects: _____

Physician name: _____ Physician Phone: _____

Procedure in the event of administration of medication: _____

Additional procedures to be followed during an emergency evacuation or off-site field trip: _____

Emergency medications are in Educators' backpack at all times. Backpacks are with Educators during indoor and outdoor play, field trips and emergency evacuations. Medication is inaccessible at all times to children.

**Attach photo
of
child here**

Schedule of Administration of Medication

	Date medication is to be administered	Time medication is to be administered	Date medication was administered	Time medication was administered	Initial of person Administering
1					
2					
3					
4					
5					
	To be filled out by parent		To be filled out by MPCC office		

Office:

100 Braemar Street
Ottawa, ON K1K 3C9
Tel.: 613-741-4776
mpcc@manorpark.ca

Community Centre:

100 Thornwood Road
Ottawa, ON K1K 4Y1
Tel.: 613-741-4753
www.manorpark.ca

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Parent/Guardian Authorization:

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on either the part of the student or the MPCC staff or its employees or agents. By requesting and consenting to the administration of medication by employees to your child, you are assuming the responsibility of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring may be reduced by carefully following instructions provided by the physician and/or the pharmacy at all times. If you consent to the administration of medication to your child by the staff, you must understand that you and not MPCC staff, will bear sole responsibility for any physical reaction that might occur.

I have read and understand that by signing this form, I authorize MPCC staff to administer prescription medication or emergency medications to my child. I also understand that I assume full responsibility for any reactions which may occur.

Parent(s) Name(s) (please print): _____

Parent(s) address: _____

Parent(s) Contact: (c) _____ (w) _____

Parent/Guardian Signature: _____ Date: _____

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