MTS OSC Medication Plan

Child's Name ______________________________

Name of Medication ______________________________

Expiry Date of Medication ______________________________

Dosage ______________________________

Where is Medication kept ______________________________

What symptoms does the Child display prior to needing medication or contacting parents ______________________________

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Medication Plan Approved by

____
Parent Signature

____
OSC Coordinator Signature

____
Printed Parent Name

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Printed Name of OSC Coordinator

Date Administered	Time Administered	Amount Administered	Person who Administeed	Parent's Name of Whom was contacted	Number of how they were contacted