

BAYSIDE SPECIAL DEVELOPMENTAL SCHOOL

Medication Details & Management Plan 2024

This form is to be completed each time there is a change in your child's medication.
It is to be completed by the Parents / Carers and, if possible, in consultation with the family doctor.

Name of Student:	Date:
Date of Birth:	
Parent / Carer Contact Number:	

Medical Condition:

Allergies:

My child requires medication: Yes No *(Please tick)*

Describe symptoms/signs of condition:

.....

Medication
Name of Medication:
Date Commenced:
Description:
Storage Requirements:
Dosage: (i.e., amount and how often)
.....
Possible side effects:
Contact details of medical professional prescribing this medication:
.....

Emergency Action Plan – Treatment and action needed if the student's condition deteriorates:

.....

.....

Signature of Parent / Carer:

(Please attach a copy of any medical management plan or emergency action plan you currently use for your child)