

## Individual Health Plan / Ongoing Medication Form (Category ii Medications)

Date: \_\_\_\_\_

Agreed Expiry Date: \_\_\_\_\_

Childs FULL Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

In what circumstances / situations should this medicine be given?: *Any changes must be made on a new form*

Dosage / method for administering medication:

*Staff Witness Required? Y / N*

Parent Signature: \_\_\_\_\_

If medicine is required during care - staff are to record details below:

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Date	Dosage	Time Given	Staff Sign	Staff Witness

Parent Acknowledgement at end of \_\_\_\_\_ period. Date \_\_\_\_\_  
*(agreed time period)*

Name \_\_\_\_\_

Signature \_\_\_\_\_

