Dunstan High School Hostel

Prescribed Medicine Action Plan

Student Name:		**D.O.B**	
History: (if relevant)			
Medicine Name		Dosage and Times	
Prescribed By		Date	
Medicine Name		Dosage and Times	
Prescribed By		Date	
Medicine Name		Dosage and Times	
Prescribed By		Date	
Medicine Name		Dosage and Times	
Prescribed By		Date	
Action Plan: (how prescriptions are to be filled, stored, given and how and when this plan is to be reviewed if necessary)			
Signed by DHS Hostel Manager		Signed by Parent/Caregiver	
This action plan may be signed by a medical practitioner or clinician instead of a parent.		Signed by Medical Practitioner	
		Date:	