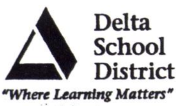

Request for Administration of Medication at School

Operation #1141.11

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Student Name	Birthdate (Y/M/D)	
Parent/Guardian	Home Phone	Business Phone
Family Physician	Phone	
Prescribing Physician	Phone	

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Condition(s) which make medication necessary

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____

Medication (Review/Update Yearly)	Dosage	Date	Directions for use

ADDITIONAL COMMENTS (POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION, ETC.)

	Physician's Signature
	Date:

C. TO BE COMPLETED BY PARENT

I request the school to give medication, as prescribed on the front of this form, to my child:
(Child's Name) ____

- I agree to supply the medication to the school in the original container with the child's name and the pharmacist's direction for use including dosage.
- If changes occur I will contact the school and provide revised instructions. I am aware I am required to update this information each September.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child may need to know of my child's condition and of the medication required.

______________________ ______________________

Date Signature of Parent/Guardian

D. COMMENTS BY PUBLIC HEALTH NURSE AFTER THE COMPLETED REQUEST IS RETURNED TO SCHOOL

____

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______________________ ______________________

Date Signature of Public Health Nurse

E. EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OR SUPERVISION OF THE MEDICATION MUST REVIEW THE INFORMATION ON THIS CARD THEN DATE AND SIGN BELOW

Date	Signature	Comments, if any