SCHOOL DISTRICT NO. 58 (NICOLA-SIMILKAMEEN)

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

A. To be completed by parent/guardian.

Name:	Birthdate (M/D/Y):	
Parent/Guardian:	Phone (home):	(work)
Physician:	Phone:	

B. To be completed by prescribing physician.

List medications that MUST be administered during school hours or (in case of emergency medication), that must be available to be administered in case of need during school sponsored activities.

Name of Medication	Dosage	Directions for Use
1.		
2.		
3.		
4.		
5.		
Additional comments (possible reactions, consequences of missing medication, etc.):		Physician's Signature:
		Date:

C. To be completed by parent/guardian.

I request the school to give medication as prescribed on the top of this form to my child whose name is recorded below.

Name of child:

I will notify the school promptly of any changes in medications ordered. Medication given to the school will be in the original container and will be replaced when outdated.

Signature of Parent/Guardian:

Date:

(continued on back of page)

D. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this form, then date and sign below.

Date	Signature	Comments (if any)