REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL FORM

School District No. 73 (Kamloops/Thompson)

Interior Health

A. To be completed by parent or guardian

Name	Birthdate Year / Month / Day	
Parent or Guardian	Home Phone	Business Phone
Physician	Phone	

B. To be completed by prescribing physician

Conditions which make medication necessary.

Name of Medication	Dosage	Directions for Use	Expiry Date of Medication
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 this form to my child whose name is recorded below. **Medication to be provided by parent in the original container and replaced when outdated.**

_____
Name of child

I will notify the school promptly of any changes in medications ordered.

_____ _____
Signature of parent or guardian.

Date _____

D. 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)
1.		
2.		
3.		
4.		
5.		