REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL FORM

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Name	Birthdate (Year, Month, Day)	
Parent or Guardian	Home Phone	Business Phone
Physician	Phone	

B. ATTACH A DUPLICATE PHARMACY LABEL OF PRESCRIBED MEDICATION OR REQUEST THAT THE PRESCRIBING PHYSICIAN COMPLETE THE FOLLOWING:

Conditions Which Make Medication Necessary

Name of Medication	Dosage	Directions for Use
1.		
2.		
3.		
4.		

Additional Comments (possible Reactions, Consequences of Missing Medication, Etc.)	Physician's Signature Date

C. TO BE COMPLETED BY PARENT OR GUARDIAN

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

Name of Child **Date**

I will Notify the School Promptly of Any Changes in Medications Ordered

Signature of Parent or Guardian

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

The information on this form is collected under the authority of the School Act. The information will be used for educational program purposes and when required, may be provided to health services, social services or other support services as outlined in sections 88 and 91 of the School Act. The information collected on this form will be protected under the Freedom of Information and Protection of Privacy Act. Questions about the collection and use of this information should be directed to the principal of your school or to the Information and Privacy Coordinator, School District #23 (Central Okanagan), 1040 Hollywood Road South, Kelowna, B.C., V1X 4N2 (250) 860-8888.