SCHOOL DISTRICT #43 (COQUITLAM)

REQUEST FOR ADMINISTRATION OF MEDICATION

NOTE: No medication will be given until this form is completed and returned to the school. It is to be completed by the parent or legal guardian and physician.

SECTION A: Section A is to be completed by the parent or legal guardian.

Student's Name: _____

Birthdate: _____ School: _____

Address: _____

Parent/Legal Guardian: _____

Phone (Home): _____ Phone (Work): _____

Other People to Contact in an Emergency:

1. _____ Phone: _____

2. _____ Phone: _____

Family Physician: _____ Phone: _____

Prescribing Physician: _____ Phone: _____

Medical Condition: _____

Medication Required: _____

PHYSICIAN TO COMPLETE INFORMATION ON NEXT PAGE

I request that staff give medication as prescribed on this form to my child:

- If non-prescription medications are to be given, a note from the doctor will be provided and the medication supplied in its original container.
- I agree to supply the medication to the school in the original container with the child's name, prescribing physician's and pharmacist's directions 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 may be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff and other personnel working with my child will need to know of my child's condition and of the medication required.

_____ _____

Signature of Parent/Legal Guardian Date

SECTION B: Section B is to be completed by a physician or licensed medical professional (i.e., nurse practioner, dentist).

NAME OF MEDICATION	DOSE	TIME	DIRECTION FOR USE
Additional Comments (possible reactions, consequences of missing medication, storage duration, etc.)			

Physician's Name

Physician's Signature

Date

Office Stamp: