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/Cell): ______________________

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: