SCHOOL DISTRICT #43 (COQUITLAM)

REQUEST FOR ADMINISTRATION OF MEDICATION

IMPORTANT: 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.

*** This form is <u>not</u> required if one of the following below plans have been completed:**

- **Anaphylactic Student Emergency Procedure Plan**
- **Delegated Care Plan**
- **Diabetes Support Plan**
- **Seizure Action Plan**

SECTION A: The parent(s) or legal guardian completes this section.

Student's Name:	DOB:
School Name:	Grade:
Address:	
Parent/Guardian(s) 1:	Phone:
Parent/Guardian(s) 2:	Phone:
Emergency Contact Information:	
Name:	Phone:
Family Physician:	Phone:
Prescribing Physician:	Phone:
Medical Condition:	
Medication Required:	

I request that SD43 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 annually in September.
- 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: This section is to be completed by a physician or licensed medical professional (e.g., Nurse Practitioner).

Name of Medication:	Dose:	Time:
Direction for use:		
Name of Medication:	Dose:	Time:
Direction for use:		
Name of Medication:	Dose:	Time:
Direction for use:		
Addition comments: (possible reactions, consequences of missing medication, storage duration, etc.)		

Physician's Name

Physician's Signature

Date

OFFICE STAMP: