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).**

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

Physician’s Name

Physician’s Signature

Date

Office Stamp: