CAMPBELL RIVER
School District 72

Request for Medication Administration at School

To be completed by parent(s)/guardian(s) of students with medical conditions requiring the administration of medication at school on an annual basis or if changes in medication occur.

A. To be completed by Parent/Guardian		
Student Name:		Birthdate (Y/M/D):
Address:		Personal Health Number:
Name of Parents: Mother:	Home or Cell Phone:	Work Phone:
Father:	Home or Cell Phone:	Work Phone:
Emergency Contact:	Home or Cell Phone:	Work Phone:
Name of Physician:		Phone:
Describe the medical condition which requires medication to be taken within school hours:		
New Condition: ☐ Yes ☐ No	Date Identified:	

B. To be completed by prescribing Physician. (This section may be completed by attaching a current pharmacy label)
(Note: Parents would need to ask for extra labels and medication printout from pharmacy).

Name of Medication: **Dosage** **Direction for Use & Storage**:

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

Additional comments (possible reactions/side effects/consequences of missed doses).

_____

_____

Signature of Physician:_____ Date: _____

The medication listed above is to be : □ administered by district staff

□ self-administered by student

The medication listed above is located: □ in a supply maintained in the school

□ on the person of the student

□ other: _____

C. To be completed by Student's Parent/Guardian:

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

Name of Child: _____ Birthdate: _____

I will provide the medication in the original labeled contained with clear instructions for administration and replace when outdated. I will notify the school promptly of any changes in medication.

Comments:_____

_____

Signature of Parent: _____ Date: _____

D. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this form then sign and date below:

Name (Please Print):	Signature:	Date:

E. MEDICAL ALERT CONDITIONS ONLY

To be completed by Public Health Nurse after the completed request is returned to the school only when a specific Medical Alert Condition as outlined in policy is involved.

Comments:

_____

_____

_____

PHN'S Signature: _____ Date: _____