SCHOOL DISTRICT NO. 35 (LANGLEY)

REQUEST FOR ADMINISTRATION OF MEDICATION

NOTE: **No medication will be given until this form is completed and returned to the school.**

A. This section is to be completed by parent or legal guardian.

Student's Name: _____ School: _____

Birthdate: _____ Address: _____

Parent or Legal Guardian: _____ Phone - Home: _____

Bus.: _____

Other person to contact in emergency: _____

Phone: _____

Family Physician: _____ Phone: _____

Prescribing Physician: _____ Phone: _____

B. Medication Required

Name of Medication	Dosage	Directions for Use	Medical Condition
1)			
2)			
3)			

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

_____

(Child's Name)

- I agree to supply the medication to the school in the **original container** with child's name and the pharmacist's direction 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 will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child may need to know of my child's condition and of the medication required.

_____ _____

Date Signature of Parent or Guardian

Revised 94/04/13 (Form originated from Student Support Services)