Vancouver Island West School District 84

Addendum to Policy E.51

Request for Administration of Medication at School

A. To be completed by Parent / Guardian:

Name of Student: ______________________ Birthdate: ______________________

Parent / Guardian: ______________________ Phone: ______________________

Describe the medical condition which requires medication to be taken within school hours:

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I request the school to administer medication as prescribed and recorded on this form. I understand that it is my responsibility to supply the medication in the original, labelled container with clear instructions for administration and to replace the medication as needed. I will notify the school promptly of any changes to the prescribed medications.

Signature of Parent ______________________ Date: ______________________

B. To be completed by Physician:

Physician's Name: ______________________ Date: ______________________

Name of Medication	Dosage	Directions for Use / Storage
1. ____________	________	____________________ ____________________ ____________________
2. ____________	________	____________________ ____________________ ____________________
3. ____________	________	____________________ ____________________ ____________________

Additional Comments (side effects, possible reactions, etc.)

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Signature of Physician:______________________ **Date**: ______________________

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C. Each staff member who is responsible for the administration of this medication will review the information on this form and then sign and date below:

Name (print)	**Signature**	**Date**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

D. School Administrator Approval

Principal Signature: ____________________________________ Date: ____________________