VANCOUVER ISLAND WEST
SCHOOL DISTRICT 84
P.O. Box 100, #2 Highway 28,
Gold River, BC V0P 1G0
Telephone: 250-283-2241
Fax: 250-283-7352

Authorization for the Administration of Medication

Name of Student: ____________________________ Birth Date: ____________________

Address: ____________________________________ Telephone: ____________________

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School: ____________________________________ Grade: ______________________

Teacher: ____

Part I - Physician's Statement:

1. Name/type of medication ____
2. Dosage/amount to be given ____
3. Frequency/times to be administered _____________________________________
4. Duration (week, month, indefinite, etc.) _________________________________
5. Anticipated reaction to medication (Symptoms, side effects, etc.) ______________

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Physician's Signature ***Address*** ***Phone*** ***Date Signed***

Part II - Parent's Request/Approval:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child.

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Parent's Signature ***Date Signed***

Part III – Designated Person(s) Administering Drugs:

I have been instructed by the Principal to administer the medication as requested by the parents and in accordance with directions listed above by the physician.

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Signature of Person(s) Administering Medication ***Date Signed***

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Principal's Signature ***Date Signed***