



SCHOOL DISTRICT NO. 73
(Kamloops - Thompson)

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL FORM

School District No. 73 (Kamloops-Thompson)



Interior Health
Every person matters

A. To be completed by parent or guardian			
Name		Birthdate	Year/Month/Day
Parent or Guardian		Home Phone	Business Phone
Physician/Health Care Practitioner		Phone:	
B. To be completed by prescribing physician Conditions which make medication necessary.			
Name of Medication	Dosage	Directions for Use	Expiry Date of Medication
1.			
2.			
3.			
4.			
5.			
Additional comments (Possible reactions, consequences of missing medication, Etc.)		Physician's signature	
		Date	
C. To be completed by parent/guardian I request the school to give medication as prescribed on this form to my child whose name is recorded below. Medication is to be provided by parent in the original container and replaced when outdated.			
Name of child			
Signature of parent or guardian			
Date			
I will notify the school promptly of any changes in medication ordered.			

Name of Medication	Dosage	Directions for Use	Expiry Date of Medication
1.			
2.			
3.			
4.			

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

Date	Signature	Comments (if any)
1.		
2.		
3.		
4.		
5.		