Administration of Prescribed Medication

To be completed when the school agrees with the parental/guardian request to administer prescribed medication. A new form must be complete when the process is initiated or when medication changes. This form is to be filed at the school.

A. To Be Completed by Parent/Guardian

Student Name (Surname, First Name)	Date of Birth (dd/mm/yyyy	Gender Preference	Family Members in same school
Address		Postal Code	Health Care #
Contact Numbers	Medical Alert Yes or No	Teachers	Classroom/Homeroom
Parent/Guardian 1		Home/Cell Phone Number	Work Number
Parent/Guardian 1		Home/Cell Phone Number	Work Number
Emergency Contact Person		Home/Cell Phone Number	Work Number

B. To Be Completed by the Attending Physician / Medical Professional
(For medications which MUST be taken during school hours or during school sponsored events (Instruction re: storage of medication for refrigeration etc.) If more than one medication is required, please use revers for more space.

Name of Medication	
Medical Condition	
Method of Administration (Dosage, Time of Administration)	
Additional Instructions	
What is the impact of a missed dose?	
Name of Physician (please print)	Phone Number #
Physician Signature	Date

C. To Be Completed By the Parent/s or Guardian/s

I will authorize and request the administration of the above medication from _____to _____ I will provide the medication in the original container with expiration date, labeled by the pharmacist.
Signature of Parent/s or Guardian Date

D. To Be Completed By the Principal or Designate

Staff designated to supervise/administer medication	
Alternate/s	
Location of Medication in the School	
Signature of Principal	Date

THIS FORM IS TO BE RETAINED BY THE SCHOOL