Request for Administration of Medication at School

Mission Public Schools

No medication will be given by school district employees until this form is completed and returned to the school.

Section A: To be completed by parent or legal guardian

Student's name _____School Name: _____

Date of Birth: _____Home Phone No.:_____

Address: _____
(street) (postal code)

Parent/Guardian Name: _____
(first) (last)

Emergency Contact Name/Phone No: _____

Dr.'s Name/Phone No.: _____ Care Card Number:_____

Section B: To be completed by prescribing physician

Include information regarding name of medication, dosage, directions for use, medical condition, possible consequences of missing medication.

_____

_____

_____

_____

_____ _____
Physician's Signature Date

Section C: To be completed by parent or legal guardian

I request that school staff give medication as prescribed in Section B of 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.
- I agree to contact the school immediately if changes occur and provide revised instructions.
- I agree to update this information each September (**or whenever there is a change in treatment – whichever comes first**).
- I agree that staff working with my child may need to know of my child's condition and of the medication required.

_____ _____
Parent's Signature Date

The personal information on this form is collected by School District No. 75 (Mission) under the authority of the School Act. The information will be used for educational purposes. This information will be protected under the Freedom of Information and Protection of Privacy Act. Questions about the collection and use of this information should be directed to the Information and Privacy Coordinator, School District No. 75, 33046 4th Avenue, Mission, BC, V2V 1S5, 826-6286.

Copies: School, Home