KEEWATIN-PATRICIA DISTRICT SCHOOL BOARD

FORM A

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER PRESCRIBED MEDICATION TO STUDENTS

TO BE FILLED IN BY PARENT/GUARDIAN

NAME OF STUDENT D.O.B.

ADDRESS PHONE

SCHOOL/GRADE TEACHER

DATES FOR ADMINISTRATION

I hereby request that the procedure specified above be administered to my child.

NOTE: The administration of this procedure will cease the last instructional day of each school year or when the procedure is no longer required as specified above, whichever comes first.

I acknowledge that I am responsible to ensure that the principal is advised of any changes in medication. I recognize and agree that the staff person administering medication is acting “in loco parentis” and not as a health professional.

I acknowledge that the staff person(s) administering medication is/are trained by me to administer medication to my child.

Signature of Parent/Guardian

Date

TO BE FILLED IN BY PHYSICIAN

Medication(s) Prescribed	Dosage	Administration

Duration of continuing medication(s): _____

1. Is it essential that this medication be taken during school hours?

   _____ YES _____ NO

2. Do you wish the public health nurse to provide follow-up reports?

   _____ YES _____ NO

3. Are there any side effects? If yes, please list:

   _____ YES _____ NO

   LIST:

Signature of Physician Date

Telephone Number and Medical Clinic

PLEASE RETURN THIS FORM TO THE PRINCIPAL