AP5200: Appendix I – Request for Administration of Physician Prescribed Medication

School District 70 Pacific Rim
4690 Roger Street Port Alberni, BC V9Y 3Z4
Telephone: 250.723.3565 Fax: 250.723.0318

School:	Teacher:	Grade:

A To be completed by PARENT OR GUARDIAN

Student's Name:		Birthdate:
Mother's Name:	Work Phone:	Home Phone:
Father's Name:	Work Phone:	Home Phone:
Emergency Contact:	Work Phone:	Home Phone:
Physician's Name:		Phone:

Describe the medical condition which requires medication to be given within school hours:

B To be completed by the attending Physician

Medication Name	Dosage	Directions for use and storage

Additional comments (possible reactions, consequences of missed dose)

I consider that the above medication and administration thereof during the school day to be in the best interest of the above named pupil, and hereby authorize its administration by the school principal or his/her designate.

Physician's Signature _____ Date: _____

C To be completed by parent or guardian

I hereby authorize the school principal or his/her designate to administer the medication as described above to my son/daughter and to contact the physician named above should there be any further questions or concerns. I further authorize the physician to release any information pertinent to this matter.

Parent / Legal Guardian Signature: **Date:**

D Each school staff member who is responsible for the administration or supervision of the medication must review this information and sign below:

Date:	Signature	Comments

This form is only valid for the current school year