REQUEST FOR ADMINISTRATION
OF MEDICATION AT SCHOOL FORM

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Name	**Birthdate (Year, Month, Day)**	
Parent or Guardian	**Home Phone**	**Business/Cell Phone**
Physician	**Phone**	

B. ATTACH A DUPLICATE PHARMACY LABEL OF PRESCRIBED MEDICATION
OR
REQUEST THAT THE PRESCRIBING PHYSICIAN COMPLETE THE FOLLOWING:
Conditions Which Make Medication Necessary

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

Additional Comments (possible Reactions, Consequences of Missing Medication, Etc.)	
If prescribing epinephrine emergency medication, it must be a single dose, single-use auto-injector for school setting with a second injector, if parents have provided a second injector, which can be given 10-15 minutes if symptoms do not improve. An oral antihistamine will not be administered by school personnel.	**Physician's Signature** _____ **Date**

Additional information can be provided on reverse side.

C. TO BE COMPLETED BY PARENT OR GUARDIAN
I request the school to give medication as prescribed to my child whose name is recorded below
Name of Child: _____

Date: _____

I will Notify the School Promptly of Any Changes in Medications Ordered

Signature of Parent or Guardian: _____

Additional information can be provided on reverse side.

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

The information collected will be used for educational program purposes and when required, may be provided to health services, social services or other support services as required by law. The information collected on this form will be protected under the Protection of Information Privacy Act (PIPA). Questions about the collection and use of this information should be directed to the principal of your school or to the Superintendent of Island Catholic Schools, Victoria, B.C., (250) 727-6893.

Additional Information: