PRINCE RUPERT School District No. 52

1350-10A Request For Administration Of Medication At School

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Name: _____ Birthdate: (yr.mo.day): _____

Parent or Guardian: _____ Home Phone: _____

Work Phone: _____

Physician: _____ Physician Phone: _____

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

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.)		_____ Physician's Signature _____ Date

C. TO BE COMPLETED BY PARENT OR GUARDIAN	D. TO BE COMPLETED BY PUBLIC HEALTH NURSE AFTER THE COMPLETED REQUEST IS RETURNED TO THE SCHOOL
I request the school to give medication as prescribed above to my child whose name is recorded below. _____ Name of Child	Comments: _____ _____ _____ _____ P.H.N. Signature Date
I will notify the school promptly of any changes in medications ordered. _____ Signature of Parent or Guardian _____ Date	Subsequent Comments, if any _____ _____ P.H.N. Signature Date

E. EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OR SUPERVISION OF THE MEDICATION MUST REVIEW THE INFORMATION ON THIS FORM AND THEN DATE AND SIGN BELOW.

Date	Signature	Comments, if any

F. TRAINING DOCUMENTATION

Name of School Staff Trained to Administer and Date of Training:

_____
_____
_____
_____
_____
_____
_____

Name	Date of Training/Review	Trainer

G. SCHEDULING OF ADMINISTRATION

Date	Time	Dosage	Signature	Print Name

(Form Revised June, 2001)