

### Instructions

**All health forms must be updated at the beginning of each school year. A new form is to be completed if the medication or dosage changes.**

If you would like school personnel to administer medication to your son/daughter, please complete this form.

Sections A is to be completed by the parent/guardian. Please print the form for your child’s prescribing physician to fill out Section B.

Prescription medication cannot be given until this form is completed and returned to the school. Medication must be provided in a container with a label from the pharmacy. Many pharmacies can provide an additional labelled container upon request. Herbal and over-the-counter medication **MUST** be in the original, clearly labelled container.

Parents are responsible for checking expiry dates of medications and providing refills as necessary.

The school staff will keep a medication log for your child.

### A. To be completed by parent or guardian

Student Name	Grade	Date of Birth (DD/MM/YYYY)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Parent or Guardian	Home Phone	Work Phone
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Physician	Physician’s Phone	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	

### Authorization

I request the school staff to give medications to my child as prescribed by my child’s physician, **as listed on page 2 of this form.**

I will notify the school promptly of any changes in medications or medication dosages. I understand that I will need to have a new **Administration of Medication** form filled out by myself and my child’s physician.

Parent/Guardian Signature	Date (DD/MM/YYYY)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

**B. To be completed by prescribing physician**

Student Name	Grade	Date of Birth (DD/MM/YYYY)

Name of Medication	Condition(s) Treated by Medication	Dosage	Directions for Use

Additional comments, possible reactions, and/or consequences of missing medication

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Signature of Physician	Physician Name	Date (YY/MM/DD)
Physician's Address	Physician's Phone	