REQUEST FOR ADMINISTRATIONOF MEDICATION AT SCHOOL form for International Students

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Name	Birthdates (yyyy/mm/dd)	
Parent or Guardian	Home Phone	Business Phone
Physician	Phone	

B. TO BE COMPLETED BY PRESERIBING 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 (yyyy/mm/dd)

C. TO BE COMPLETED BY PARENT OR GUARDIAN

I request the school to give medication as prescribed on the front of this form to my child whose name is recorded below.

_____

Name of Child

I will notify the school promptly of any changes in medications ordered.

_____

Signature of Parent or Guardian

_____

Date (yyyy/mm/dd)

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 on this form is collected under the authority of the School Act, sections 13 and 97. The information will be used for educational program purposes and when required, may be provided to health services or other support services as outlined in section 97(2) of the School Act. The information collected on this form will be protected under the Freedom of Information and Protection of Privacy Act. Questions about the collection and use of the information should be directed to the principal of your school.