

KEEWATIN-PATRICIA DISTRICT SCHOOL BOARD

FORM A

REQUEST FOR SCHOOL STAFF TO ADMINISTER PRESCRIBED MEDICATION TO STUDENTS

TO BE FILLED IN BY PARENT/GUARDIAN

NAME OF STUDENT _____ D.O.B. _____

ADDRESS _____ PHONE _____

SCHOOL/GRADE _____ TEACHER _____

DATES FOR ADMINISTRATION _____

I hereby request that the procedure specified above be administered to my child.

I acknowledge that I am responsible to ensure that the principal is advised of any changes in medication. I recognize and agree that the staff person administering medication is acting "in loco parentis" and not as a health professional.

I acknowledge that the staff person(s) administering medication is/are trained by me **and/or a medical professional** to administer medication to my child.

Signature of Parent/Guardian

Date

TO BE FILLED IN BY PHYSICIAN

| Medication(s) Prescribed | Dosage | Administration |
|--------------------------|--------|----------------|
| | | |
| | | |

Duration of continuing medication(s): _____

- Is it essential that this medication be taken during school hours?
_____ YES _____ NO
- Do you wish the public health nurse to provide follow-up reports?
_____ YES _____ NO
- Are there any side effects? If yes, please list:
_____ YES _____ NO
- This medical information needs to be updated annually.*
_____ YES _____ NO

LIST:

Signature of Physician _____ Date

Telephone Number and Medical Clinic

PLEASE RETURN THIS FORM TO THE PRINCIPAL