KEEWATIN-PATRICIA DISTRICT SCHOOL BOARD

FORM D

REQUEST FOR PARENT/GUARDIAN ADMINISTRATION OF PRESCRIBED MEDICATION TO STUDENTS

NAME OF STUDENT D.O.B.

ADDRESS PHONE

SCHOOL/GRADE TEACHER

DATES OF ADMINISTRATION:

I hereby request permission to enter the school to administer medication to my child. I understand that I will report to the office prior to the administration of the prescribed medication.

Signature of Parent/Guardian

Date

TO BE FILLED IN BY PARENT/GUARDIAN

Prescribed Medication(s)	Dosage	Administration

1. Are there any side effects? If yes, please list:

_____ YES _____ NO

LIST:

PLEASE RETURN THIS FORM TO THE PRINCIPAL