Heritage Christian School

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A Ministry of the Kelowna Christian Centre Society

Request for Administration of Medication at School Form

1. To be Completed by Parent or Guardian

Name	Birth date of student(s). (yyyy/mm/dd)
Parent or Guardian	Home Phone Business Phone
Physician	Phone

2. To be Completed by Prescribing Physician
Conditions which make medications necessary

Name of Medication	Dosage	Directions for Use: Please use other side if necessary.
1.		
2.		
3.		
4.		

Additional Comments (possible reactions, consequences of missing medications, etc.)

_____

_____

_____

_____ _____

Physician

3. To be Completed by Parent or Guardian

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

_____
Name of Child

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

_____ _____
Signature of Parent or Guardian Date

4. To be completed by public health nurse after the completed request is returned to the school.

_____ _____
Public Health Nurse's Signature Date

Comments:

_____

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5. 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