MEDICATION ADMINISTRATION FORM

SCHOOL: _____

A) PARENT/GUARDIAN – COMPLETE AND SIGN

STUDENT'S NAME (Last, First)	**DOB (Day/Mo/Year)**	
MEDICAL CONDITION **□ Anaphylaxis □ Blood Clotting Disorder □ Diabetes □ Heart Condition □ Seizure Disorder □ Severe Asthma □ Other**		
PHYSICIAN	**PHONE**	**PHN/CARE CARD NUMBER**
PARENT/GUARDIAN	**DAYTIME PHONE** **CELL PHONE**	**EMAIL ADDRESS**
I request the school to give medication as prescribed to my child. I understand I must provide the medication in a sealed original container that is clearly labelled. I will notify the school promptly of any changes in medications ordered.		
SIGNATURE OF PARENT/GUARDIAN	**DATE (Day/Mo/Year)**	

B) PHYSICIAN – COMPLETE AND SIGN

CONDITION(S) WHICH MAKE MEDICATION NECESSARY:

NOTE:

- **Epi Pen is the only medication school staff will administer for anaphylactic reactions as per School Anaphylaxis Policy.**
- **Staff may only administer student medication that has been prescribed by a physician; staff shall not administer non-prescribed medication. (Policy)**

NAME OF MEDICATION	**DOSAGE**	**DIRECTIONS FOR USE**
1)		
2)		
3)		
ADDITIONAL COMMENTS, POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION, ETC.		
SIGNATURE OF PHYSICIAN		**DATE (Day/Mo/Year)**

C) ALL STAFF RESPONSIBLE FOR ADMINISTRATION/SUPERVISION OF MEDICATION – REVIEW AND SIGN

NAME	**SIGNATURE**	**DATE (Day/Mo/Year)**

This information is subject to and protected by the Freedom of Information and Protection of Privacy Act.