

A) PARENT/GUARDIAN – COMPLETE AND SIGN

STUDENT'S NAME (Last, First)		DOB (Day/Mo/Year)
MEDICAL CONDITION <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Blood Clotting Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Severe Asthma <input type="checkbox"/> Other:		
PHYSICIAN	PHONE	PHN/CARE CARD NUMBER
PARENT/GUARDIAN	DAYTIME PHONE	EMAIL ADDRESS
	CELL PHONE	
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: <ul style="list-style-type: none"> ▪ 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.