REQUEST TO ADMINISTER MEDICATION

This form is to be completed by Parent or Guardian to allow teaching staff to administer medication.

Specific directions must also be written on the medication. **Unlabelled medicines will not be given under any circumstances.**

Name of Student: __________________________________________________________________________

Medication: __________________________ Period of Use: ________________________________

Specific Directions: ______________________________________________________________________

Supplying Pharmacy: __________________________ Phone No.: __________________________

SIGNATURE OF PARENT / GUARDIAN: ______________________________________________________________________

DATE: _________________________________

A record sheet for each child indicating when medication was given will be kept at school.

**EMERGENCY ACTION PLAN**

The medical treatment and action needed if the student's condition deteriorates.

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