Langley Schools

SCHOOL DISTRICT NO. 35 (LANGLEY)

REQUEST FOR ADMINISTRATION OF MEDICATION

NOTE: No medication will be administered until this form is completed and returned to the school.

A. This section is to be completed by a parent or legal guardian.

Student's Name: ________________________________ School: _______________________________

Birth date: _______________ Grade: ____ Address: ____

Parent or Legal Guardian: ____

Phone - Home: _____________ Bus.: ______________ Cell: ______________________

Emergency contact: ____ Phone: ____________________

Family Physician: ____ Phone: ____________________

Prescribing Physician: ____ Phone: ____________________

B. Medication Required

Name of Medication	Dosage	Directions for Use	Medical Condition
1)			
2)			
3)			

C. I request that staff administer medication as prescribed on this form to my child:

____

(Student's Name)

- I agree to supply the medication to the school in the **original container** with my child's name and the pharmacist's direction for use, including dosage.
- If changes occur I will contact the school and provide revised written instructions from a physician or pharmacist. I am aware I am required to update this information each September or sooner if required.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child may need to know of my child's condition and of the medication required
- I hereby give permission for my child's medical condition and required medication to be shared with relevant staff as required. Upon request, the Principal will provide the names of staff members that have been informed of my child's condition.

________________________________ ____

Date Signature of Parent or Legal Guardian