



**VANCOUVER BOARD OF EDUCATION  
REQUEST FOR ADMINISTRATION  
OF MEDICATION AT SCHOOL**

**A. TO BE COMPLETED BY PARENT OR GUARDIAN**

NAME		BIRTHDATE (YEAR, MONTH, DAY)	
PARENT OR GUARDIAN		HOME PHONE	BUSINESS PHONE
PHYSICIAN		PHONE	

**B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN**  
CONDITIONS (WHICH MAKE MEDICATION NECESSARY)

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		

ADDITIONAL COMMENTS, POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION ETC.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

**C. TO BE COMPLETED BY PARENT OR GUARDIAN**

I REQUEST THE SCHOOL TO GIVE MEDICATION AS PRESCRIBED ON THE FRONT OF THIS FORM TO MY CHILD WHOSE NAME IS RECORDED BELOW.

\_\_\_\_\_  
NAME OF CHILD

I WILL NOTIFY THE SCHOOL PROMPTLY OF ANY CHANGES IN MEDICATIONS ORDERED

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

**D. CONSULTATION (AS NEEDED) WITH COMMUNITY HEALTH NURSE AFTER THE COMPLETED REQUEST IS RETURNED TO THE SCHOOL AT REQUEST OF SCHOOL ADMINISTRATOR**

COMMENTS

\_\_\_\_\_  
CHN'S SIGNATURE

\_\_\_\_\_  
DATE

SUBSEQUENT COMMENTS, IF ANY:

\_\_\_\_\_  
SCHOOL ADMINISTRATOR

\_\_\_\_\_  
DATE

**E. EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE MEDICATION MUST REVIEW THE INFORMATION ON THIS CARD THEN DATE AND SIGN BELOW.**

DATE	SIGNATURE	COMMENTS, IF ANY