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