APF REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL FORM

CARIBOO - CHILCOTIN SCHOOL DISTRICT

A. To be completed by parent or caregiver

Name	Birthdate Month / Day / Year	
Parent or caregiver	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	Expiry Date of Medication
1.			
2.			
3.			
4.			
5.			

Additional comments
(possible reactions, consequences of missing medication, Etc.)

Physician's signature

Date

C. To be completed by parent/caregiver.

I request the school to give medication as prescribed on this form to my child whose name is recorded below. **Medication to be provided by parent in the original container and replaced when outdated.**

Name of child

I will notify the school promptly of any changes in medications ordered.

Signature of parent or caregiver.

Date

D. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this card then date and sign below.

Date	Signature	Comments (if any)
1.		
2.		
3.		
4.		
5.		

ADMINISTRATIVE GUIDELINES FOR MANAGING STUDENTS WITH MEDICAL ALERT CONDITIONS
School District No. 27 (Cariboo-Chilcotin)