Form 316-01

Cowichan Valley School District

School _____

Teacher _____

Grade _____

REQUEST FOR ADMINISTRATION OF PHYSICIAN PRESCRIBED MEDICATION

A. To be completed by PARENT or GUARDIAN

Student's Name: _____ Birth Date: _____

Parents/Guardian: Phone Numbers:

Mother: _____ Home: _____ Work: _____

Father: _____ Home: _____ Work: _____

Emergency Contact: Relationship: Phone Numbers:

_____ Home: _____ Work: _____

Doctor: _____ Phone Number: _____

Describe the medical condition which required medication to be given within school hours:

_____

B. Complete this section by attaching a copy of the pharmacy label or have your physician complete

Medication Name	Dosage	Directions for use and storage
_____	_____	_____
_____	_____	_____

Additional Comments: (possible reactions, consequences of missed doses)

Doctor's Signature: _____ _____

(if required) (Parent/Legal Guardian Signature) (Date)

C. To be completed by parent or guardian:
I request the school to give medication as described above to my child whose name is:

_____

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

_____ _____
(Parent/Legal Guardian Signature) (Date)

This card is valid for 2 years unless cancelled in writing.

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

_____ _____
(Parent/Legal Guardian Signature) (Date)