HASTINGS AND PRINCE EDWARD DISTRICT SCHOOL BOARD

FORM 230-10	
Adopted	April 2005
Last Revised	May 2015
Review Date	May 2020

REQUEST FOR ADMINISTRATION OF ORAL MEDICATION

School: _____ Student Name: _____

Date of Birth: _____ Address: _____

Parent/Guardian Name: _____ Phone #: _____ Cell #: _____

Physician's Instructions for Administering Oral Medication: ***(please print clearly)***

Physician's Name: _____

Name of Medication: _____

Dosage and Instructions (e.g. amount & date): _____

Frequency and Method of Administration: _____

Possible Side Effects: _____

Action to be Taken if Side Effects Occur: _____

Special Storage Instructions: _____

_____ _____

Physician's Signature **Date**

Parent/Guardian Authorization:

I hereby request that the above medication and procedures as outlined by our physician be administered orally to my son, daughter, ward. _____ (Please print Student's full name)

I understand that the Hastings and Prince Edward District School Board and its employees will not be legally responsible for the administration of the medication.

_____ _____

Parent/Guardian's Signature **Date**

Note: This request will expire June 30th of each school year.

This information is collected under the authority of the Education Act and in compliance with the Municipal Freedom of Information and Protection of Privacy Act. Should you have questions about this form, please contact the Principal of the school.