SCHOOL DISTRICT No. 69 (Qualicum)

APPENDIX X – STUDENT HEALTH AND COMMON MEDICAL CONDITIONS

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL

Dear Parents/Guardians: This information must be updated annually OR if any changes in condition and/or treatment during the school year. Please review, update and return the completed form to your school office within one week of receiving it.

School:	***Grade:***	***Homeroom Teacher:***	
STUDENT INFORMATION:			
Student Usual Surname:		*Student Usual First Name:*	
Student Health Care #:		*Who has custody:*	
Parent/Legal Guardian Name 1:		*Primary Telephone #1:*	
Parent/Legal Guardian Name 2:		*Primary Telephone #2:*	

THIS SECTION TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S NAME (please print): _____

PHYSICIAN'S TELEPHONE NUMBER: _____

Name of Medication(s): _____

_____

Details of Self-Administration of Medication(s): _____

_____

_____

Physician's Authorization (Signature): _____ Date: _____

THIS SECTION TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

I understand that it is the responsibility of my child, _____

to carry _____ on their person.
(Specify type of medication)

PLEASE PRINT

Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Student*: _____ Date: _____
(*If 18 years of age or older)

Name of Physician: _____ Physician Phone #: _____