

REQUEST FOR ADMINISTRATION OF ORAL MEDICATION

Student : _____ Telephone#: _____
 Address: _____
 Date of Birth: _____ School: _____ Grade: _____
 Parent's Name: _____ Bus. Phone #: _____

PHYSICIAN'S INSTRUCTIONS FOR ADMINISTERING ORAL MEDICATION

(please type or print clearly)

Name of Medication: _____
 Dosage: _____
 Frequency and Method of Administration: _____
 Dates for which authorization applies (length of time medication is to be given): _____

Possible side effects: _____

Special Storage and Safekeeping Requirements (if necessary): _____

Physician's Name: _____
 Physician's Address: _____
 Physician's Telephone Number: _____
 Physician's Signature: _____

PARENT/GUARDIAN AUTHORIZATION

We hereby request that the above medication and procedure as outline by our physician be administered orally to our child.

We understand that the Durham District School Board and its employees will not legally be responsible for the administration of the medication.

Parent/Guardian Signature: _____
 Date: _____

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