

Beautiful Plains School Division

Box 700, Neepawa, MB R0J 1H0 Tel: (204) 476-2388 Fax: (204) 476-3606 Email: bpsd@bpsd.mb.ca

ADMINISTRATION OF PRESCRIBED MEDICATION

(prescription length exceeding 2 weeks)

TO THE PARENT(s) / GUARDIAN(s): School staff will voluntarily assist in administering prescribed medication to students if required, ONLY if this is completed and returned to the school. A new form is required each time the prescription changes. If it continues unchanged, a new form is required each September.

TO BE COMPLETED BY PARENT(s) / GUARDIAN(s):

I request that school staff assist in administering prescribed medication to my child.

NAME OF STUDENT: _____

NAME OF PARENT/GUARDIAN: _____

TELEPHONE: (home) _____ (work) _____

NAME OF MEDICATION: _____

REASON FOR MEDICATION: _____

DOSAGE AND FREQUENCY: _____

TIME OF ADMINISTRATION: _____

STORAGE REQUIREMENTS: (Refrigeration, etc.) _____

OTHER INSTRUCTIONS: _____

NAME OF PRESCRIBING DOCTOR: _____

ADDRESS: _____

PHONE: _____

NAME OF DISPENSING PHARMACY: _____

PHONE: _____

ANY SIDE EFFECTS: _____

I authorize the school to contact the doctor or the dispensing pharmacist for further information, and I authorize them to release any further information requested by the school.

Date

Parent/Guardian Signature