REQUEST FOR ADMINISTRATION OF ORAL MEDIATION

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.