Chilliwack School District

Form 425A

REQUEST FOR ADMINISTRATION OF

MEDICATION AT SCHOOL

Student Name: _____ School Name: _____

A. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Condition(s) which make medication necessary: _____

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		
Additional comments: (possible reactions, consequences of missing medication, storage duration)		Physicians Name: *(please print)*
		Physicians Signature:
		Date:

B. TO BE COMPLETED BY PARENT OR GUARDIAN – INFORMED AUTHORIZATION AND RELEASE

I request the school to give medication (must be in the original container) as prescribed on this form to my child, whose name is: _____. I will notify the school, in writing, promptly of any changes in medication or dosages ordered. I will provide the medications listed above.

☐ EPIPEN – I request that the administration of the EpiPen be provided. I understand that the service will be provided by a person without medical or nursing training. It is my responsibility as parent / guardian to provide the school with current EpiPens for my child's use and care.

_____
Date

_____ _____
Name – Parent/Guardian Signature – Parent/Guardian

C. INFORMATION & TRAINING

Prior to administration of any medication, each designated staff member who is responsible for the administration or supervision of the medication must date and sign below to indicate they have been informed of administration and/or has been trained, where required, by the public health nurse.

School Year: _____

DATE	STUDENT NAME (please print)	STAFF NAME (please print)	SIGNATURE

D. AUTHORIZATION

_____ _____

Date Principal's Name

_____

Principal's Signature

E. TRAINING & PROCEDURES REVIEWED

_____ _____

Date PHN's Name

_____

PHN's Signature