

**Request for Administration  
of Medication at School**

**A. TO BE COMPLETED BY PARENT OR GUARDIAN**

_____	_____	_____
STUDENT NAME	BIRTH DATE (year/month/day)	PERSONAL HEALTH NUMBER
_____	_____	_____
PARENT OR GUARDIAN NAME	HOME TELEPHONE	BUSINESS TELEPHONE

**NOTE TO PHARMACIST:** Please apply Pharmacy label for prescriptions from doctors only.  
Non-prescription medications **not** accepted.

ORIGINAL  
PHARMACY LABEL  
ONLY

**B. TO BE COMPLETED BY PARENT OR GUARDIAN**

I request school staff to administer medication as prescribed on this form to my child: \_\_\_\_\_  
(student's name)

I, \_\_\_\_\_ will notify the school promptly of any changes in medication  
(Parent or Guardian - please print name)

\_\_\_\_\_  
(Signature of Parent or Guardian)

Short Term medication: This medication should be given at \_\_\_\_\_ (time).

**C. TO BE COMPLETED BY SCHOOL PRINCIPAL**

The information on this form has been reviewed with appropriate staff.

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_