Form 316-1

ADMINISTRATION OF MEDICATION/ MEDICAL ASSISTANCE REQUEST

Student: _____ D.O.B.: _____

Parent(s)/Guardian(s): _____

Telephone (residence): _____
(work): _____

Address: _____

Information to assist in reaching parent/guardian if not at above address:
_____
_____
_____

Family Physician: _____ Telephone: _____

Medical condition requiring attention by school personnel:
_____
_____
_____

Specific procedures requested to be performed by school personnel:
_____
_____
_____

Types and description of medication: (possible side effects)
_____
_____
_____

I (we) hereby request and grant consent for the above mentioned task(s) to be performed by school personnel and further acknowledge that the teacher or other school division personnel are not trained medical personnel.

I (we) shall advise, in writing, the school of any changes in my child's condition which may affect services required at the school.

Signature(s): _____ Date: _____

_____

ADMINISTRATION OF MEDICATIONS

STUDENT	PRESCRIPTION	DATE	TIME	DISPENSED BY