APPENDIX I

REQUEST FOR ADMINISTRATION OF ORAL MEDICATION

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.