RICHMOND
SCHOOL DISTRICT NO.38

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: _____