CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

REQUEST FOR ADMINISTRATION OF MEDICATION

Student _____ Date _____

Address _____ Telephone _____

School _____ Teacher _____

Physician's Instructions for Administering Medication:

Administration of this medication during school hours is necessary for this child's attendance at school.

Name/Type of medication: _____

Dosage/amount to be given: _____

Frequency/Times to be administered: _____

Duration: _____

Physician's Signature _____

Telephone Number _____

Parent/Guardian Authorization

We hereby request that the above medication and procedure as outlined by our physician be administered to our child.

We understand that the Catholic District School Board of Eastern Ontario will not be legally responsible for the administration of the medication.

_____

Parent/Guardian Signature

Note: This request will expire June 30 of each school year or at the end of the duration as specified above.