Interlake School Division

Request to Administer Medication Form - AP 4010 – F1

Interlake School Division recognizes that some students may require medication during the school day. Where the administration of this medication is not possible by parent, guardian, or appropriate medical authority; is necessary during school hours; and the student is not able to manage this medication administration, the following Request for Medication Administration must be completed in its entirety. Requests to administer medication apply to prescription and over the counter medications (if recommended by a physician and accompanied by original pharmacy label and/or written physician instructions). For a school to agree to administer medications, parents or guardians must provide all required information to the school and meet all conditions as established by the Division (see attached list). A new request is required for each school year and for changes in medication.

To be completed by parent(s) or guardian(s).

1. I request that medication be administered to: _____
   (name of student)

   Date of birth (d/m/y): _____ Personal Health Info Number (9 digit): _____

   Address: _____ Home Phone Number: _____

2. Name of parent(s)/guardian(s): _____

   Address: _____ Work Phone #: _____

   Phone #: _____

3. Name of prescribing physician: _____

   Office address: _____ Phone #: _____

4. Name of dispensing pharmacy: _____

   Address: _____Phone #: _____

5. Name of medication(s): _____

   Date prescription filled: _____

6. Reason(s) for medication(s): _____

   _____

7. Dosage and method of administration: _____

8. Time of administration at school: _____

9. Start date of medication (d/m/y): _____

10. Stop date of medication (d/m/y): _____

11. I confirm that the first dose of medication(s) was administered at home or hospital:
    (please initial) _____

12. I confirm that the first dose of medication(s) was well tolerated by this child:
    (please initial) _____

13. Storage requirements (if any): _____

14. Description of side effects: _____

_____

15. Response to side effects: _____

_____

16. I certify that the information provided is accurate:

_____ Signature of Parent/Guardian

_____ Date

If requested, pharmacies will provide two original pharmacy labeled containers. One container may be used exclusively in the school. This is recommended.

Conditions for Acceptance of Medication Administration

☐ Completed Request for Medication Administration

☐ Medication delivered to school by a responsible adult

☐ Prescription medication is in an original pharmacy labeled container which identifies:

a. name of child
b. name of prescribing physician
c. name of medication
d. dose
e. frequency and route of administration
f. name of the pharmacy
g. date the prescription was filled

☐ Label is on the medication and not just the package

☐ Over-the-counter medication that is recommended by a physician is accompanied by an original pharmacy label with administration instruction and /or clearly written instructions from a physician

☐ Measuring instruments are provided.

_____ _____

Signature of Principal or Designate Date