FORM 200.2a: Request for Medication at School

School: ____

Date: ____

Parent/Guardian Name: ____

Student Name: ____

Medication Required While Attending School:

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Frequency and Dosage: ____

Duration: ____

Medical Procedure Required:

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____

Training Required: Yes: No:

If yes, date of training: ____

Physician/Medical Personnel Signature: ____

Public Health Nurse: ____

Attending School Personnel, including position:

____

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I authorize the administration of required medication to my child by the personnel named above. I sign this release absolving the School District No. 8 (Kootenay Lake) Board of Trustees, the school and the personnel named from any and all liability arising from the administration of the medication or the performance of the medical procedure required.

Signature: ____ Date: ______________________________

Related Policy: Nil
Related Administrative Procedure: 200.2 Student Medication
Revised: August 22, 2018