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: ____

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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