Chilliwack School District

Form 506.1 (D)

REQUEST FOR TEMPORARY ADMINISTRATION OF

NON-PRESCRIPTION MEDICATION AT SCHOOL

Student Name: _____ School Name: _____

TO BE COMPLETED BY PARENT / GUARDIAN
Condition(s) which make medication necessary: _____

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		
Additional comments: (possible reactions, consequences of missing medication, storage duration)		

I request the school to give medication (must be provided in the original container) as prescribed on this form to my child, _____ for the following dates (not to exceed 5 calendar days). I will notify the school promptly of any changes in medications needed. I will provide the medications listed above.

_____
Date

_____ _____
Name – Parent/Guardian Signature – Parent/Guardian