Chilliwack School District

Form 425C

# 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