Fort McMurray Public Schools

# REQUEST FOR THE ADMINISTRATION OF MEDICATION OR MEDICAL TREATMENT

Student Name: ______________________ Phone Number: __________

Physician: ______________________ Phone Number: __________

1. Name of Medication and/or Treatment

2. Purpose of Medication and/or Treatment

3. Time Intervals for Administration

4. Dosage and Procedure for Administration

5. Possible Side Effects

6. Procedure to Follow in Case of Adverse Reaction

7. Special Storage Instructions for the Medication

8. Security Requirements to Prevent Risk to Others

9. Termination Date for Administration

10. Authorization and Procedure for Student Self-Administration

11. Training Required

12. Medication to be Administered by:

| | |
|---|---|
| Signature of Parent/Legal Guardian | Date |
| Signature of Doctor | Date |
| Signature of Principal: | Date |
| Signature of Individual Administering the Treatment/Medication: | Date |

Fort McMurray Public School Division
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