ADDENDUM B

Lester B. Pearson School Board
Request and Authorization for the Distribution of Medication at School

Name of Student: _____ _____
Last Name First Name

Name of Parent/Guardian: _____

Address: _____

_____

_____

Tel: (Residence) (_____) _____ Tel: (Work Place) (_____) _____
Area Code Area Code

Tel: (Cell) (_____)_____
Area Code

Physician's Name: _____ Tel: (____) _____
Area Code

Name of Medication: _____

The medication is to be:

- θ Self-administered by student under supervision of staff member.
- θ Distributed to student by staff member designated by the principal.
- θ Carried and self-administered

Instructions: _____

_____

_____

_____

Precautions to be taken in storing medication: _____

Prescription Starting Date: _____
Day Month Year

Prescription Completion Date: _____
Day Month Year

Parent's/Guardian's Signature: _____ Date: _____

THIS FORM IS VALID ONLY UNTIL COMPLETION OR ONE YEAR FROM THE STARTING DATE