659-3 New Credit Road
R.R. #6
Hagersville, Ontario N0A 1H0
Phone: 905-768-3222
Fax: 905-768-4100

Date: _____

To be completed by Parent/Guardian

Name of Student: _____
Address: _____ City: _____ Postal Code: _____
Telephone: _____ Birthdate: Day: _____ Month _____ Year: _____
Parent/ Guardian: _____ Contact #: _____
Employer: _____ Phone #: _____
In case of Emergency, contact: _____ Phone #: _____
Alternate Emergency Contact: _____ Phone #: _____
Alternate Emergency Contact: _____ Phone #: _____

Parental Approval

I hereby request and give permission to Lloyd S. King Elementary School (LSK) to administer oral medication to my child according to the instructions of the physician. In making this request, I release any staff member of LSK and the New Credit First Nation from any legal liability that may result from the administration of medication.

_____ _____
Signature of Parent/ Guardian Date

Condition of the patient for which oral medication is necessary

_____

Special Instructions: (i.e. storage, training required by staff)

_____

Medication Prescribed	**Dosage**	**Time(s) to be given**
1.		
2.		
3.		

Duration of continuing medication: _____
Possible side effects: _____
Will it be detrimental to the child's health if a single dose is omitted? _____
Do you wish the community/ public health nurse to provide follow-up? _____
Prescribing physician's name: _____
Office Address and Phone #: _____