



<b>POLICY NUMBER:</b>	<b>APP.SMW.F.1</b>	<b>APPROVAL DATE:</b>	<b>LAST REVISED:</b>
		<b>May 6, 2002</b>	<b>April 3, 2006</b>

REQUEST FOR SCHOOL ASSISTANCE WITH HEALTH CARE #7A560

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

1. Name of procedure(s) or medication(s): \_\_\_\_\_

\_\_\_\_\_

2. Cautions/Notable Side-effects (if any): \_\_\_\_\_

\_\_\_\_\_

3. Administration frequency during school hours:

\_\_\_\_\_

4. End date (if appropriate): \_\_\_\_\_

**Note:**

- It is the responsibility of the parent/guardian to ensure that medical information is current and that adequate, in-date medication has been provided for use at the school.
- Prior to administering medication that has not been prescribed by a physician; a principal may require a parent to provide a note from a physician supporting the request.
- The administration of this procedure/medication will cease on June 30<sup>th</sup> of each school year or when the procedure or medication is changed or no longer required. In the event of a change in the procedure or medication (i.e. dosage, medication, etc.) a new form must be completed and submitted to the school.
- All medication must be in its original container and clearly labeled with the student's name and prescribed dosage.

I hereby request that the procedure specified above be administered to my child.

\_\_\_\_\_  
**Patient/Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

This information is being collected pursuant to the provisions of the Freedom of Information Act and Protection of Privacy Act, and under the authority of the Education Act. This confidential form will be shared among education professionals. Personal information shall not be used except for the purpose of which it was obtained and compiled.

Any questions with respect to this information should be directed to your school principal.