NON PRESCRIPTION MEDICATION ADMINISTRATION FORM

Selkirk Montessori School – 2970 Jutland Rd. E. Victoria, BC V8T 5K2 250-384-3414

Parent /Guardian – Please complete, sign and return to the office.

Student Name :_____ Date of Birth (D/M/Y)_____

Care Card Number:_____

Physician Name_____ Phone #_____

Parent/Guardian

Mother's Name:_____ Daytime Phone:_____

Cell Phone:_____ Home Phone:_____ Email:_____

Father's Name:_____ Daytime Phone:_____

Cell Phone:_____ Home Phone: _____Email:_____

I give permission for my child to take the following non prescription medication as I have prescribed below. I understand that I must provide the medication in a sealed original container that is clearly labeled with my child's name on it. All non – prescription medications will remain with the staff on field trips.

Parental/Guardian Signature: _____Date:_____

NAME OF MEDICATION	DOSAGE ALLOWED	DIRECTIONS FOR USE

Signature of all the staff responsible, for possible administration/supervision of medication.

NAME	SIGNATURE	DATE (d/m/y)