

School District No. 71 (Comox Valley)
MEDICAL ALERT AND PRESCRIBED MEDICATION RECORD

TO BE COMPLETED BY PARENTS/GUARDIANS OF STUDENTS WITH MEDICAL CONDITIONS
AND BY DISTRICT EMPLOYEES WITH MEDICAL CONDITIONS

The information on this form must be updated at least annually, as required by Management Regulation 6011MR1

Student/Employee _____	Birthdate _____
Student's mother _____	Work _____ Home _____
Student's father _____	Work _____ Home _____
Emergency contact _____	Work _____ Home _____
Name of physician _____	Phone: _____
Describe the medical condition which requires medication to be taken within school/work hours: _____ _____	

The medication listed below is to be: <input type="checkbox"/> administered by district staff <input type="checkbox"/> self-administered by student/subject employee
The medication listed below is located: <input type="checkbox"/> in a supply maintained in the school/work site administration area
<input type="checkbox"/> on the person of the student/subject employee
<input type="checkbox"/> other: _____

THIS SECTION REQUIRES THE SIGNATURE OF YOUR PHYSICIAN. This section may be completed by attaching a current pharmacy medical label.		
NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE AND STORAGE
_____	_____	_____ _____
Additional comments (possible reactions, consequences of missed doses): _____ _____		
SIGNATURE OF PHYSICIAN _____		DATE _____

PLEASE COMPLETE REVERSE

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TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN:

I request that the school give medication as described above to my child, whose name is:

TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN OR BY SUBJECT EMPLOYEE:

I will notify the school or work site promptly of any changes in the medications described on this form and will ensure that any medications provided by me to the school or work site will be replenished as needed.

SIGNATURE _____ DATE _____
PARENT/GUARDIAN OR SUBJECT EMPLOYEE

FOR OFFICE USE ONLY

The employees listed below are responsible for the supervision of the medication described on this form and are the only district employees trained and permitted to administer the medications listed. All qualified employees must sign below.

NAME (Please print)	SIGNATURE	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE _____ DATE _____
PARENT/GUARDIAN OR SUBJECT EMPLOYEE