SASKATOON
CHRISTIAN SCHOOL

STUDENT PRESCRIBED MEDICATION FORM

One form/student

School Year (YYYY-YYYY): _____

Complete this form if your child has a medical condition requiring prescribed medication on a regular or emergency basis.

STUDENT INFORMATION

Surname:	Given Name(s):
Birthdate (YYYY-MM-DD):	Grade:

MEDICATION INFORMATION & INSTRUCTIONS

All medication must have the proper instructions for administering, handling, and storage.

Medication Name:	Dosage:	Expiry Date:
Prescribing Doctor's Name:	Phone:	
Instructions:		

ALLERGY & PRE-EXISTING EMERGENCY CONDITIONS

Food/Insect Stings/Other:

Check all that apply: ☐ History of Anaphylaxis ☐ Asthma ☐ Seizure Disorder ☐ Diabetes

PARENT ACKNOWLEDGEMENT/AUTHORIZATION

I/we will provide medication and updated medical information annually and when changes occur.

I/we authorize school staff to administer the described medication and acknowledge they are not medical professionals.

SIGN HERE

Parent/Guardian Signature:	Date (YYYY-MM-DD):

SCHOOL APPROVAL

SIGN HERE

Principal/Designate:	Date (YYYY-MM-DD):