HOLY FAMILY ROMAN CATHOLIC
SEPARATE SCHOOL DIVISION NO. 140

5122 APPENDIX 3

PHYSICIAN CONSENT TO ADMINSTER MEDICATION

Name: _____ School: _____

DOB (D/M/Y): _____ Grade: _____ Teacher: _____

Home Address: _____ S.H.S.Personal Health Number: _____

Parent(s)/Guardian(s) Phone:	
Residence	Work

Parent(s)/Guardian(s) Phone:	
Residence	Work

Emergency Contact: _____ Phone Number(s): _____ or _____

TO BE COMPLETED BY PHYSICIAN

Name of Physician:		**Telephone:**	
Address of Physician:			
Name of Pharmacy:		**Telephone:**	

Medication Prescribed	Dosage	Times for Administration	Side Effects

For further information regarding the above medication call DIAL ACCESS (Saskatoon) at 1-800-665-3784

Side Effects if Medication is Not Taken:

Effective Date: _____ **Termination Date:** _____

Other Pertinent Information :

Physician's Signature: _____ **Date:** _____