FORM B

KILLARNEY SCHOOL
TURTLE MOUNTAIN SCHOOL DIVISION
BOX 2500 KILLARNEY, MANITOBA ROK IGO
TELEPHONE: (204) 523-4696
FAX: (204) 523-8545

_____ , 2021

Dear Doctor:

RE: Name _____

Address _____

Birthdate _____

School and Grade _____

We have been informed that the above mentioned child, a patient of yours, is required to take medication during school hours.

Since this procedure involves additional responsibilities on behalf of school personnel, may we ask your cooperation in reviewing the need for medication during school hours for this child? If you decide it is essential, please record the name of the drug, the dose, and other necessary instructions. Your signature indicating the need for the administration of this drug by school personnel is essential.

Yours sincerely,

Student Services, Killarney School

Name of drug _____

Dose to be given _____

Frequency of dose _____

Possible side effects _____

Response to side effects _____

_____ _____ M. D.

DATE SIGNATURE

This form will be in effect for the school year: _____