FORM C

TURTLE MOUNTAIN SCHOOL DIVISION
BOX 280 KILLARNEY, MANITOBA R0K 1G0
TELEPHONE: (204) 523-7531
FAX: (204) 523-7269

_____, 20 _____

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,

Name of drug _____

Dose to be given _____

Frequency of dose _____

Possible side effects _____

Response to side effects _____

_____ _____ M.D.

DATE SIGNATURE

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