Annapolis Valley
Regional Centre for Education

AP 401.10-1k
Sample or Trial Medication Form

This form must be completed by a physician when prescribing a *sample or trial medication* that is being provided to a student to take during school hours. For prescriptions filled at a pharmacy, the pharmacist will provide the parent with the necessary information for the school.

Physician's Contact Information (Address stamp)

Patient (Student) Information:

Name: _____ DOB (dd-mm-yyyy): _____

Address: _____

Sample or Trial Medication Information:

Name:	
Dose: (amount in mg or tablets)	
Time of Administration: (during school hours)	
Possible Side Effects:	☐ Change in appetite ☐ Diarrhea ☐ Dizziness ☐ Drowsiness ☐ Fever ☐ Headaches ☐ Nausea ☐ Vomiting Other:
Storage Instructions:	☐ Store at room temperature ☐ Refrigerate ☐ Other _____
Special Instructions: (if applicable)	

Authorization Period:

Prescription is authorized to be administered: _____ to _____
dd-mm-yyyy dd-mm-yyyy

_____ _____
(Physician Signature) (Date)

_____ _____
(Parent/Legal Guardian Signature) (Date)