



AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION TO STUDENTS

Authorization for the Administration of Prescribed Medication to Students

To be completed by Parent/Guardian

Student Identification

Name _____
Year Month Day

Date of Birth _____

Phone No. _____

Address _____

MHSC No. _____

PHIN No. _____

Parent/Guardian Identification

Father's Name _____

Work No. _____

Cell No. _____

Mother's Name _____

Work No. _____

Cell No. _____

School Identification

Name of School _____

Address _____

Phone No. _____

Physician Identification

Name _____

Address _____

Phone No. _____

Emergency Contact if Unable to Reach Parent/Guardian

Name _____ Phone No. _____

Confirm that the first dose was administered and no adverse reactions occurred prior to coming to school: Yes No

 Parent/Guardian Signature

To be completed by Parent/Guardian in Consultation with Physician and Pharmacist

Medication Information:

Name of Physician Consulted _____ Phone No. _____

Name of Pharmacist Consulted _____ Phone No. _____

Name of Medication _____

Reason for Medication _____

Dosage and Method of Administration _____



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Approximate time(s) of administration during school day _____

Specific Storage Requirements
Side effects to watch for and actions required if these side effects are observed _____

Action required if medication is missed _____

Parent/Guardian Authorization

I have read the attached policy and regulation and hereby request and authorize the school to administer the prescribed medication to my child in accordance with the regulation, including that:

- (1) medications presented to a school not meeting the conditions of this regulation cannot be administered by school division staff. The parent/guardian retains full responsibility for administering the medication.
- (2) The parent/guardian or designated adult is responsible for the delivery and supply of the medication. If requested, pharmacies will provide two original pharmacy labeled containers.
- (3) The medication container must have the dispensing instructions noted on it and must have the official label of the pharmacy or a doctor's note to accompany the medication:
 - name of the student
 - name of the prescribing physician
 - name of the pharmacy
 - dose
 - frequency and method of administration
 - name of the medication
 - date the prescription was filled
- (4) It is the responsibility of the parent/guardian to notify the school in writing of any changes in dosage or time of administration of medication.
- (5) The designated employee (or alternate) is to administer the prescribed medication.
- (6) Authorization must be renewed annually with student registration or upon change in medication.

I hereby request and authorize the school to administer the prescribed medication to my child. I also certify that the first dosage of medication was given at home and no adverse reactions were tolerated. School personnel are authorized to contact the physician/pharmacist regarding any questions as to the administration of this medication.

Date

Signature of Parent/Guardian



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OR

I hereby certify that _____ (student's name) is able to safely, competently and consistently manage his/her own medication, and I authorize the self-administration of the medication _____ (name of medication). I understand that I am responsible for consequences which may result from lost or misplaced medications.

_____ Date

_____ Signature of Parent/Guardian

Office Use

Individual Administering Medication: _____ Date Trained: _____

Signature: _____

Alternate: Name: _____ Date Trained: _____

Signature: _____

Training Provided by: _____

Administrator Signature

Effective Date:	December 7, 2004	Policy
Amended Date:	March 21, 2006	Regulation
Board Motion(s):	635/04; 162/06	Exhibit XXX
Legal/Cross Reference:		