AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION
To be completed by Parent/Guardian

STUDENT IDENTIFICATION:
Name _____
Date of Birth _____
M.H.S.C. # P.H.I.N. # _____

PARENT/GUARDIAN IDENTIFICATION:
Names _____
Work # Mother _____
Work # Father _____
Phone _____
Address _____

SCHOOL IDENTIFICATION:
Name of School _____
Address _____
Phone _____

PHYSICIAN IDENTIFICATION:
Name _____
Address _____
Phone _____

Emergency contact if unable to reach parent/guardian:
Name _____ Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN IN CONSULTATION WITH PHYSICIAN AND/OR PHARMACIST

MEDICATION INFORMATION: _____
Name of Physician Consulted _____ Phone _____
Name of Pharmacist Consulted _____ Phone _____
Name of Medication _____
Reason for Medication _____
Dosage and Method of Administration _____
Approximate time(s) of administration during the school day _____
Start Date : y/m/d _____ End Date : y/m/d _____
Specific storage requirements _____
Side effects to watch for and actions required if these side effects are observed _____
_____
Action required if medication missed _____

a) Parents must make every effort to ensure that medication does not need to be administered during school hours. The Division reserves the right to correspond with the physician/pharmacist should concerns about administration be presented by the staff.
b) The parent/guardian or designated adult is responsible for the delivery and supply of the medication. If requested, pharmacies will provide two original pharmacy labelled containers. Unused medication will be returned to the parent(s)/guardian(s).
c) The medication container must carry the official label from the druggist stating the child's name, physician's name, name of the drug, the dosage to be administered and the time of day it is to be given. The container must also have the official label of the pharmacy.
d) 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.
e) The school administrator will designate a specific staff member to administer the medication to the student on a regular basis. If the designated staff member is unavailable for whatever reason, the school administrator will ensure that the person assigned to the task has full knowledge of the facts.
f) The school administration reserves the right to refuse to administer prescribed medication to any child whose parent(s) or legal guardian(s) has not fully completed this "Administration and Authorization of Prescribed Medication" form.
g) The school administration will contact the parent(s) or guardian(s) immediately and, if they are not available, the assistance of a qualified person should be sought if a student will not take the prescribed medication.
h) Authorization automatically terminates June 30th of the current school year 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 the medication was given at home and was well tolerated. School personnel are authorized to contact the physician/pharmacist regarding any questions as to the administration of the medication.

Parent/Guardian Signature _____ Date _____

School Administration Signature _____ Date received by the school _____

Adopted September 1, 2009		