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 ____________________

Date of Birth (Year / Month / Day) ____________________

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 ❍

Medications required for emergency situations are exempt.

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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 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 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, (medications required for emergency situations are exempt). School personnel are authorized to contact the physician/pharmacist regarding 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 their 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	Review Date: November 13, 2019
Amended Date:	March 21, 2006; February 21, 2023	
Board Motion(s):	635/04; 162/06; 36/23	
Legal/Cross Reference:		