Huron-Superior Catholic District School Board

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

NAME OF STUDENT: _____ ***BIRTH DATE:*** _____

ADDRESS: _____ ***TELEPHONE:*** _____

_____

SCHOOL: _____ ***GRADE:*** _____ ***TEACHER:*** _____

PART 1 - PHYSICIAN'S STATEMENT

1. *Name/type of medication:* _____
2. *Dosage/amount to be given:* _____
3. *Frequency/times to be administered:* _____
4. *Dates for Authorization (Day/Month/Year)* _____
   (Start - D/M/Y) *(End - D/M/Y)*
5. *Storage/Safekeeping requirements:* _____
6. *Anticipated reaction to medication:* _____
   (Symptoms, side effects, etc...) _____

_____ _____ _____ _____

Physician's Signature *Address* *Telephone* *Date Signed*

PART II - PARENT(S)/GUARDIAN(S) REQUEST, APPROVAL, AND WAIVER

I hereby release and hold harmless the Huron-Superior Catholic District School Board and its employees from any liability arising as a consequence of the administration of the prescribed medication in the manner prescribed.

I hereby request and give my permission for the above-named school to administer the medication prescribed on this form to my child.

_____ _____ _____

Parent's/Guardian's Name Signature Date Signed

PART III - DESIGNATED PERSON(S) ADMINISTERING PRESCRIBED MEDICATION

I have agreed to administer the medication as requested by the parents/guardians and in accordance with directions listed above by the physician.

_____ _____ _____

Name of Person(s) Administering Medication Signature Date Signed

Copies to: Physician
Parents/ Guardians
School

NB: This form will be completed for each school year, and whenever there is any change in the administration of prescribed medication.

Revised: 2018 02 10