



# Huron-Superior Catholic

## DISTRICT SCHOOL BOARD

### AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

NAME OF STUDENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

#### **PART I - 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

#### **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 Signature Date

#### **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.

\_\_\_\_\_  
Signature of Person(s) Administering Medication Date

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