Appendix A
(front)

Louis Riel School Division

Authorization for the Administration of Prescribed Medication

To be Completed by Parent/Guardian

Student Identification:

Name _____

Date of Birth _____(YY/MM/DD)

Phone # _____

Address _____

M.H.S.C.# _____

Parent/Guardian Identification:

Name _____

Work # Father _____

Name _____

Work # Mother _____

P.H.I.N.# _____

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

Medication Information:

Name of Physician who prescribed medication: _____ Phone # _____

Name of Pharmacist who filled prescription: _____ Phone # _____

Name of Medication _____

Reason for Medication _____

Dosage and Method of Administration _____

Approximate time(s) of administration during the school day _____

Start Date _____ (YY/MM/DD) End Date _____ (YY/MM/DD)

Specific storage requirements _____

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

_____

Action required if medication missed _____

_____

Appendix A
(Back)

Louis Riel School Division
Authorization for the Administration of Prescribed Medication

Parent/Guardian Authorization

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

a) 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.

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.

c) The medication container must have the dispensing instructions noted on it and must have the official label of the pharmacy.
- 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

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 designated employee (or alternate) is to administer the prescribed medication.

f) Authorization must be renewed annually with student registration and whenever changes in medication and/or dosage occur.

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.

_____ _____
(Date) (Signature of Parent/Guardian)

School Use Only

Date _____

Staff Designate who will administer medication _____

Signature _____ Date Trained _____

Alternate - Name _____

Signature _____ Date Trained _____

Training provided by _____

_____
Signature of Administration

Adopted – Jan. 8 '08