Authorization for the Administration of Medication

(Prescription or Over-the-Counter)

School name: _____ School year: _____

Student information

Name _____ Birthdate _____/_____/_____
Year Month Day

Parent/guardian _____ Daytime phone(s) _____

Parent/guardian _____ Daytime phone(s) _____

Emergency contact _____ Daytime phone(s) _____

Medication information

Name of medication _____ Strength _____

Reason for medication _____

Instruction _____ Time of Day to Be Administered _____

Route (e.g., oral, eye drops) _____

Start date (if applicable) _____ End date (if applicable) _____

Storage requirements (e.g., refrigeration) _____

Physician that prescribed medication _____ Phone _____

Physician signature *(required for over-the-counter medication only)* _____

Parent/guardian authorization

I have read the school division's Administration of Medication Policy and I understand that:

a) Prescribed medication must be provided to the school in the original pharmacy labelled container. Over-the-counter medication must be provided to the school in the original container.
b) Medication must be delivered to the school by the parent/guardian or designated adult.
c) Changes in medication dosage and time of administration must be provided to the school in clearly written instructions from the prescribing physician.

□ Yes, the first dose of the above medication has been administered at home and well tolerated.
The first dose does not need to be administered at home If the medication is required for emergency situations (e.g., adrenaline auto-injector for anaphylaxis, reliever medication for asthma, rescue medication for seizures).

I hereby request and authorize the school to administer the medication named above to my child.

_____ _____
Parent/guardian signature Date

This authorization automatically terminates June 30th of the current school year or upon change in medication.

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

_____

Action required if medication missed _____

_____

School Use Only

Date _____

Staff Designate who will administer medication _____

Signature _____ Date Trained _____

Alternate - Name _____

Signature _____ Date Trained _____

Training provided by _____

_____

Signature of Administration