Prairie Rose School Division

Authorization for the Administration of Prescribed Medication

(Prescription or Over-the-Counter)

To be Completed by Parent/Guardian

Student Identification:

Name _____

Date of Birth _____

M.H.S.C. # P.H.I.N. # _____

Phone _____

Parent/Guardian Identification:

Names_____

Work # Mother _____

Work # Father _____

Address _____

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 in Consultation with Physician and/or Pharmacist

Medication Information:

Name of Physician Consulted _____ Phone _____

Name of Pharmacist Consulted _____ Phone _____

Name of Medication _____

Reason for Medication _____

Dosage and Method of Administration _____

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

Start Date _____ End Date _____

y/m/d y/m/d

Specific storage requirements _____

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

_____

Action required if medication missed _____

Note: The first dosage of medication should be administered at home.

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Parent/Guardian Authorization

a) Medications presented to a school not meeting the conditions of this policy will not be administered by Divisional 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 labeled containers.

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

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 school administrator (or designate) is to administer the prescribed medication.

f) Authorization automatically terminates June 30th of the current school year 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 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)

_____ _____

(Date) (Signature of Principal)

Original authorization to be retained in student's cum file. This authorization automatically terminates June 30th of the current school year or upon change in medication.