

**ADMINISTRATION AND STORAGE OF PRESCRIBED MEDICATION**  
**Authorization**

**PART A**

To be completed by attending physician  
(Please type or print)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

**PHYSICIAN'S STATEMENT RE: ADMINISTERING MEDICATION DURING SCHOOL HOURS**

In my opinion, it is necessary that the following medication be administered during school hours:

1. a) Medication Prescribed:  b) Method of Administration:  c) Dosage:  d) Time(s):
2. Must medication be taken during school hours?
3. Possible side effects of medication:
4. Action to be taken should a reaction occur:
5. Allergies which should be noted:
6. Additional instructions (e.g. storage of medication, etc.):
7. Expected date of discontinuation of medication:

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be placed in the student's Medical File.**

**ADMINISTRATION AND STORAGE OF PRESCRIBED MEDICATION**  
**Authorization**

**PART B**

To be completed by Parents/Guardians  
(Please type or print)

This is to authorize the administration of the medication(s) prescribed as mentioned by the attending physician for:

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Medic Alert I.D. Yes \_\_\_ No \_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I/we hereby release the Burlington Parental Christian School Society Inc., its employees and agents from all actions, causes of action, suits, losses, damages or injuries howsoever caused, by negligence or otherwise, arising out of the administration or failure to administer medication as provided herein. I/we also agree to indemnify the Board, its employees or agents for any losses or damages sustained by them as a result of any such actions, or proceedings being commenced against them.

It is acknowledged that the employees or agents of the Board are not medically trained to administer medication.

Parents/Guardians

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:**

Parents/Guardians are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS (those in which the medication was supplied from the pharmacist/physician.) The containers should be PROPERLY LABELLED indicating the STUDENT'S NAME AND ADMINISTRATION/STORAGE DIRECTIONS.

The medication will be delivered, according to an agreed schedule and amount to the Principal or designated person for safekeeping, unless otherwise determined.

**Note:**

This request will terminate either on June 30 of each school year or when the prescription changes or expires.

In case of **EMERGENCY**, the contact person is:

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| <ul style="list-style-type: none"><li>• The information gathered in this form is collected pursuant to the education Act and Municipal Freedom of Information and Protection of Privacy Act, and will be stored in the student's Medical File.</li><li>• The information will be used to assist with meeting the health needs of the student.</li><li>• If there are any questions about the information gathered on this form, please contact the school principal.</li></ul> |
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