

**SELF-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.**

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

**PART B**

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

This is to authorize the self-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**

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on the part of the student. By requesting and/or consenting to the self-administration of medication, you are assuming the risk of an unexpected reaction occurring. It is understood that the changes of such a reaction occurring may be reduced by carefully following the instructions provided by the physician and /or pharmacy at all times. If you consent to the self-administration of medication, you must understand that you will bear sole responsibility for any physical reaction that might occur.

I have read the above and I understand that in requesting and consenting to the self-administration of medication, I am assuming the risks associated with doing so. The above medication shall be self-administered by the student in accordance with the procedure outlined above by the physician.

Name of Medication \_\_\_\_\_ Prescription No. \_\_\_\_\_

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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