Peterborough Victoria Northumberland and Clarington Catholic District School Board

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Name: ______________________ Date of Birth: ______________________

Home Address: ______________________

City: ______________ Postal Code: __________ Home Phone:

School: ______________________ Teacher: ______________________

Parents /Guardians must immediately notify the Principal or designate if administration of medication outlined in the Authorization for Administration of Medication form is not to occur on a given day. Such requests shall also be documented in the Student Medication Log.

MEDICATION INFORMATION

1. Name of Medication: ______________________
2. Amount to be Given (e.g. mg.): ______________________
3. Time(s) of Administration: ______________________
4. Duration of Administration: ______________________
5. Possible Side Effects: ______________________
6. I am confirming that this student carry the above stated medication on their person while at school. ☐YES ☐NO

   ____

7. I am confirming that this student self-administers the above stated medication on their person while at school. ☐YES ☐NO

8 . Physician's Name: ______________________

Physician's Signature: ______________________ Date: ______________

Address: ______________________ Phone: ______________

Please share any written documentation which would be helpful.

CONSENT FOR STUDENT TO CARRY AND SELF-ADMINISTER ASTHMA AND OTHER MEDICATIONS

We agree that, ______________________*(name of student)*

- ○ will carry his/her prescribed medications - ______________________, on their person at all times.
- ○ **can self-administer** his/her prescribed medications while at school and during school- related activities
- ○ will carry his/her prescribed asthma medications on their person at all times
- ○ **can carry** his/her prescribed asthma medications and delivery devices to manage asthma while at school and during school-related activities.
- ○ **can self-administer** his/her prescribed asthma medications and delivery devices to manage asthma while at school and during school- related activities
- ○ **requires assistance** with administering his/her prescribed asthma medications and delivery devices to manage asthma while at school and during school-related activities.
- ○ We will inform the school of any change in medication or delivery device. The medications cannot be beyond the expiration date

Parent/Guardian Name: ______________________

Parent/Guardian Signature: ______________________ Date: ______________

DESIGNATED PERSON ADMINISTERING MEDICATION

I, ________________________________,(print name) agree to administer the medication herein requested by the Parent/Guardian as prescribed by the Physician and to maintain a log of such administration.

Signature of Person Administering Medication: ____________________ Date: ____________________

Principal's Signature: ____________________ Date: ____________________

PARENT'S/GUARDIAN'S APPROVAL

Parent's/Guardian's Signature: ____________________ Date: ____________________

A new Authorization for Administration of Medication must be submitted each school year and whenever medication is modified.

Information Collection Authorization: This information is collected pursuant to the Board's education responsibilities as set out in the Education Act and is within guidelines set out in the Municipal Freedom of Information and Protection of Privacy Act, 1989. The information is collected for education purposes and will be used to meet student medical needs. This information will become part of the Ontario Student Record. Any questions with respect to this information should be directed to the School Principal.
Users: Staff administering medication or special services.

02/16 Copies to: 1. Parent /Guardian 2. Ontario Student Record (O.S.R.)