HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

PART II -<u>To be completed by Parent/Guardian when medication is initiated, changed, *and* annually at the beginning of each new school year.</u>

.(Please type or print)

This is to authorize the administration of the medication(s) prescribed by the attending physician from _____ to for:
date date

Student's Name: _____ **Birthdate: (yyyy/mm/dd)** _____

School: _____

Medic Alert I. D.: Yes _____ No _____

- I give permission for my child to self-administer the medication prescribed by the attending physician. Yes No __
  Signature of Parent/Guardian: _____
  Date:_____ (Year,
  Month, Day)

- I release and agree to indemnify the Hamilton-Wentworth Catholic District School Board and its staff from any liability or damages incurred by any party as a consequence of the administration or lack of administration of medication to my child.
  Signature of Parent/Guardian: _____
  Date:_____ (Year,
  Month, Day)

NOTE:

- ☐ Parents are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS, preferably those in which the medication was supplied from the pharmacist/physician.
- ☐ The containers should be PROPERLY LABELLED indicating the NAME of MEDICATION, STUDENT'S NAME, AND ADMINISTRATION DIRECTIONS.
- ☐ The medication will be delivered by parent/guardian, according to an agreed schedule, to the Principal or designated person for safe keeping, unless otherwise determined.

In case of EMERGENCY, the contact persons are:

Name _____ Name _____

Telephone_____ Telephone _____

Relationship _____ Relationship_____

Under The Municipal Freedom of Information and Protection of Privacy Act, 1989, information in forms and documents pertaining to a student registered/enrolled within The Hamilton-Wentworth Catholic District School Board is collected under the legal authority of The Education Act, and its Regulations, and the Ontario Student Record (O.S.R.) Guideline, 1989. This information is being collected to ensure that the educational program which is provided meets your child's needs.

*This side for prescription meds only

Appendix 4

HAMILTON WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Part I **To be completed by the attending physician when medication is initiated or changed.**
(Please type or print)

Student's Name: Birthdate:

Address: School:

This is to advise that I have prescribed the administration of the following medication listed below for those days when the above-mentioned student is in school:

1. Name of Medication _____

   Method of Administration _____

   Dosage Time(s) _____

2. Expected date of discontinuation: _____

3. Must the medication be taken during school hours? _____

4. Contra-indications to giving medication: _____

5. Please specify possible hazards or side effects of medication:
   _____
   _____

6. Action to be taken should a reaction occur: _____
   _____

7. Allergies which should be noted (if applicable): _____
   _____

8. Additional instructions (e.g., storage of medication, etc.):

Physician's Name: Telephone: _____

Address: _____

Physician's Signature: Date: _____

IS-96-56 (To be placed in Documentation File of O.S.R).