Dufferin-Peel Catholic District School Board

GF 035

AUTHORIZATION FOR STORAGE AND ADMINISTRATION OF MEDICATIONS

THIS FORM REQUIRES UPDATES EACH YEAR

Student Information

Student Name: _____

Student Address: _____

Phone: _____ Date of Birth: _____

School: _____ School Year: _____

This form is to authorize the administration of:

☐ Prescribed medications: _____

☐ Non-prescribed medications: _____

Note:
Parents and guardians are requested to provide **prescribed medication** in the original container supplied by the pharmacy or physician. The container MUST include the pharmacy dispensing label with administration directions for use. All doses must be pre-measured prior to being sent to school for storage and administration. Non-prescribed medication should also be in its original container for identification and administration purposes. **School staff will not cut, crush, dissolve, measure, or alter medications**.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Contact Information:

Name:	**Relationship:**	**Contact Numbers:**

Municipal Freedom of Information and Protection of Privacy Act: Personal information on this form is collected under the legal authority of the *Education Act*, R.S.O 1980, c.129. This information will be used to determine the authorized method of storage and for administration of prescribed medication. Questions regarding the collection should be directed to the Principal.

Copy to OSR

Medication Information:
If more than one medication is being stored and administered, please complete additional copies of this page.

Name of medication: _____

Method of Administration: _____

Dosage: _____ Time/Frequency: _____

Possible side effects: _____

Actions to be taken in the event of a reaction: _____

Allergies of note: _____

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

Disposal of medication: _____

Expected date of discontinuation of medication: _____

Medical Practitioner/Healthcare Provider Information and Signature for Prescribed Medications

Medical Practitioner/ Healthcare Provider Name: _____ Profession/ Role: _____

Medical Practitioner/ Healthcare Provider Phone: _____ Medical Practitioner/ Healthcare Provider Fax: _____

Medical Practitioner/ Healthcare Provider Address: _____

Signature: _____ Date: _____

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