Dufferin-Peel Catholic District School Board

GF 035

Authorization for Storage and Administration of Medications
Part A: Prescribed Medication

Name of Student: _____ D.O.B. _____
Day/Month/Year

Address:_____ Telephone:_____

School: _____ School Year:_____

Medication Prescribed_____

Method of Administration_____

Dosage_____ Time/Frequency_____

Must medication be taken during school hours?_____

Possible side effects of medication_____

Action to be taken should a reaction occur_____

Allergies which should be noted_____

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

_____

Expected date of discontinuation of medication _____

Physician's Name _____ Telephone _____ Fax_____

Address _____

Physician's Signature _____Date:_____

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.

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Authorization for Storage and Administration of Medications
Part B: Prescribed and Non-Prescribed Medications

Both Part A and Part B must be completed for prescribed medication(s).
PART B to be completed by parent/guardian for prescribed and non-prescribed medication(s).

This is to authorize the administration of:

☐ Prescribed Medication(s) :_____

☐ Non-Prescribed medication(s) :_____

NOTE : Parents/Guardians are requested to provide medication in the original container supplied by the pharmacy/physician. The container MUST BE properly labeled with the student's name and administration directions.

The medication will be delivered to the office to the attention of the principal or designated person for safe keeping, unless otherwise determined.

Name of Student: _____ D.O.B. _____
Day/Month/Year

Address:_____ Telephone:_____

School: _____ School Year:_____

Medic Alert ID: Yes ☐ No ☐

NOTE : Dufferin-Peel CDSB is participating in the No Child Without® initiative through the Canadian MedicAlert ® Foundation. Registered schools can support families access free MedicAlert ® bracelets and supporting resources through this initiative found at **http://www.nochildwithout.ca**

Parent/Guardian Signature_____

Date_____

In case of emergency, the contact person is:

Name _____ Telephone _____

Relationship:_____

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