Authorization for Administration of Medication

Before any prescription or non-prescription medication may be administered to a student, the school Principal must receive written parental consent and written instruction from the child's parent, physician or dentist. All written instructions and consent forms shall be filled in the school office. – **Administrative Procedure 316**

I hereby request and give my permission for the below-named school to administer medication prescribed on this form to my child. I make this request in the knowledge that school personnel have no special training or have limited training in the administration of the medication. Parents/guardians must inform the principal of any changes in the administration of the medication. A new request/authorization form must be completed and given to the principal. In addition, I accept responsibility to ensure the safe transportation of these medications to and from school. I hereby acknowledge that at my request the principal, or her/his designate, has been authorized to administer the prescribed medication:

Name of Student _____ **Date of Birth _____**

Address _____ **Phone Number _____**

School _____ **Teacher/Class _____**

Please complete the following information:

1. Name/type of Medication

   _____

2. Details for administration and/or situation in which this medication would be required

   _____

   _____

3. Time (s) medication is to be administered_____

4. Emergency/Contact Information

   _____

   _____

PHYSICIAN'S STATEMENT

5. Length of time for which a drug is to be administered

   _____

   _____

6. Dosage to be administered:_____

7. Action to be taken in the event of possible hazards or side effects

   _____

   _____

Physician's Name: _____ **Signature: _____**

Person Administering Medication_____Signature:_____

Alternate People to Administer Medication _____

The above information has been reviewed and verified. And I hereby release the principal and/or her/his designate and the Medicine Hat Catholic Board of Education from any claim for any harmful effects resulting from the administration of the prescribed medication and I hereby agree to indemnify and save harmless the principal and/or her/his designates and the Medicine Hat Catholic Board of Education from all claims that may be made as a result thereof. I have received a copy of the board's policy on the administration of medication, and agree to follow the policy.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date: _____**

Signature of School Principal: _____ **Date: _____**

IN THE CASE OF FOSTER PARENTS, PLEASE OBTAIN THE SIGNATURE OF AN ALBERTA SOCIAL SERVICES REPRESENTATIVE OR OFFICIAL