Windsor-Essex Catholic District School Board **Pr ST:11 FORM A**

Request & Authorization for the ADMINISTRATION OF MEDICATION at School

THIS FORM IS TO BE RETURNED TO THE SCHOOL

PART 1 TO BE COMPLETED BY THE PARENT/GUARDIAN/STUDENT – if not a minor

I request the _____ to ensure that _____ _____
School Name of Student D.O.B.

receive the medication prescribed by _____ as attached.

Notes:
1. The medication provided must be supplied in the original prescription container, labeled with the name of the medicine, the physician's name, the amount to be taken and the time(s) to be taken, expiration date and the student's name.
2. Authorization must be signed by the student or, in the case of a minor, by the parent or legal guardian, whichever is the appropriate legal authority. In the case of a person who is disabled to such a degree as to be incapable to give consent, the next of kin may authorize the administration of medicine.
3. It is understood that the request is being made for school staff to undertake the administration of medicine, and that such staff are not medical professionals. The staff will make every effort to ensure that medication is administered in an appropriate manner, and at the times requested.

ACKNOWLEDGEMENT:

I acknowledge that non-medical personnel are being asked to undertake the administration of medication or medical procedures to my son/daughter ___ _____. I understand that there is some inherent risk in having non-medical personnel undertake the administration of medications and procedures, and accept the risks associated with this request.

Date: _____ Signed: _____
(parent/guardian/student – if not a minor)

Address: _____

PART 2 TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN (Long Term Illness)

The following medication has been prescribed. It is necessary for this medication to be administered during school hours by personnel other than the parent/legal guardian:

Medication/Dosage/Method of Administration:		
Indications for Administration :		
Other Instructions:		
Cautions/Notable Side Effects:		
Period of Authorization: From:	To:	
Prescribing Physician's Name: (Please print)		
Address:		Telephone Number:
Date:	Prescribing Physician's Signature	

Authorization for the collection of this information is in the Education Act. The information will be used to assist the WECDSB in implementing health support services to students, including the administration of prescribed medication. Users of this information may be principals, teachers, support staff, volunteers, bus operators and drivers. This form will be kept for a minimum period of one school year and then shredded. Contact person concerning this collection is the school principal.

NOTE: This form is valid until the prescription expires or is altered by the physician, whichever comes first. It is the responsibility of the parent/guardian/student to ensure that a new form is completed when required and returned to the school. Any cost associated with the completion of this medical request is the sole responsibility of the parent/guardian.