ADMINISTRATION OF PRESCRIBED MEDICATION

☐140 Borough Drive
Scarborough, M1P 4N6

☐ 1 Civic Centre Court
Etobicoke, M9C 2B3

☐5050 Yonge Street
North York, M2N 5N8

To be completed when the school agrees with the parental request to administer medication. A new form must be completed when the process is initiated or when medication changes. This form is to be filed at the school.

A. TO BE COMPLETED BY THE PARENT

Student Name *(Surname, First Name)*	D.O.B (*dd/mmm/yyyy)*	Gender ☐M ☐F	Student #
Address	Postal Code		Health Care #
Student Home Phone #	Medic Alert I.D ☐ Yes ☐ No	Teacher	Classroom #
Parent/Guardian (1)	Home Phone #		Work Phone #
Parent/Guardian (2)	Home Phone #		Work Phone #
Emergency Contact Person			Phone #

B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(For medication which MUST be taken during school hours or during school sponsored events (Instructions re storage of medication for refrigeration, etc.)) **If more than 1 medication is required, please see reverse for more space.**

Name of Medication	
Medical Condition	
Method of Administration (Dosage, time of administration)	
Additional Instructions	
What is the impact of a missed dose?	
Name of Physician (please print)	Phone #
Physician Signature	Date

C. TO BE COMPLETED BY THE PARENT(S)/GUARDIAN(S)

_____

_____

_____

I will authorize and request the administration of the above medication from _____ to _____
I will provide the medication in the original container with expiration date, labeled by my pharmacist.

Signature of Parent(s)/Guardian(s)	Date

D. TO BE COMPLETED BY THE PRINCIPAL OR DESIGNATE

Staff designated to supervise/administer medication	
Alternate(s)	
Location of Medication the School	
Signature of Principal	Date

B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(For medication which MUST be taken during school hours or during school sponsored events (Instructions re storage of medication for refrigeration, etc.))

Name of Medication	
Medical Condition	
Method of Administration *(dosage, time of administration)*	
Additional Instructions	
What is the impact of a missed dose?	
Name of Physician *(please print)*	Phone #
Physician Signature	Date

B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(For medication which MUST be taken during school hours or during school sponsored events (Instructions re storage of medication for refrigeration, etc.)

Name of Medication	
Medical Condition	
Method of Administration *(dosage, time of administration)*	
Additional Instructions	
What is the impact of a missed dose?	
Name of Physician *(please print)*	Phone #
Physician Signature	Date

THIS FORM IS TO BE RETAINED BY THE SCHOOL