Authorization for Daily Administration of Prescription Medication

(Please print)

STUDENT'S NAME: ______________________ **STUDENT'S BIRTH DATE:** ______________________

ADDRESS: ______________________ **TELEPHONE:** ______________________

SCHOOL: ______________________ **TEACHER:** ______________________

EMERGENCY: Contact Person:______________________ **Phone:**______________________

REQUEST AND APPROVAL OF PARENT/GUARDIAN:

I hereby request and give permission for prescription medication prescribed herein to be administered to my child who is named above for the duration indicated by the Physician. I will provide the medication in the original container.

NOTE: IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO NOTIFY THE PRINCIPAL OF ANY CHANGES IN THE PRESCRIBED MEDICATION OR IN THE ADMINISTRATION OF THAT MEDICATION. THIS AUTHORIZATION WILL EXPIRE ON THE DATE INDICATED BY THE PHYSICIAN OR ON JUNE 30TH OF EACH SCHOOL YEAR.

I hereby release the Thames Valley District School Board, including its' employees, staff, personnel and agents (hereinafter "TVDSB") from any liability for loss, damage or injury to my child's person or property which may arise out of the administration of medication authorized as provided herein, unless the damages, injuries or loss are a result of the gross negligence of the TVDSB.

Parent/Guardian Signature ______________________ Date Signed ______________________

I hereby give my child permission to self-administer their own medication as outlined below.

Parent/Guardian Signature ______________________ Date Signed ______________________

PLEASE TYPE OR PRINT IN BLOCK LETTERS

STATEMENT OF PHYSICIAN:

1. Name/type of prescription medicine______________________
2. Dosage/amount to be given______________________
3. Frequency/times for administration______________________
4. Instructions for administration______________________
5. Duration______________________
6. Anticipated reaction to medication (symptoms, side effects)______________________

Medical Practitioner's Name (Print or type)

Medical Practitioner's Signature Date Signed

Medical Practitioner's Address Medical Practitioner's Telephone Number

STATEMENT OF PERSON ADMINISTERING PRESCRIPTION MEDICATION:

I have agreed to administer the prescription medication as herein requested by the parent/guardian and as prescribed by the Physician. I will maintain a log of such administration.

Principal's Name Signature of Principal Date Signed

Copies to: [Principal(Original), Parent/Guardian, Physician]

Notice of Collection: The personal information provided on this form and any other correspondence relating to involvement in Board programs is collected by the Thames Valley District School Board under the authority of the Education Act and Regulations (R.S.O. 1990 c.E.2) as amended. The information will be used to register the student in a school, for the collection of applicable student/activity fees, as well as for any consistent purpose. Information is shared with employees such that they may carry out their job duties. In addition, the information may be used or disclosed to comply with legislation, for compelling circumstances affecting health and safety or discipline, as required in circumstances related to law enforcement matters, or in accordance with any other Act. For questions about this collection, contact the Board's Freedom of Information Co-ordinator, Thames Valley District School Board, 1250 Dundas Street, London, Ontario, N5W 5P2, Telephone 519-452-2000 ext. 20218.