

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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(Revised April 2013)