HWDSB

Appendix F

AUTHORIZATION OF ADMINISTRATION OF ORAL PRESCRIPTION MEDICATION

A new form must be completed at the beginning of each school year, or when the medication changes.
This form is to be retained until the end of the school year.

Student's Name:	**School:** **Class:** **Room:**
Date of Birth:	**Home Phone:** **Business Phone:**
Emergency Contact Name and Relationship to Student:	**Emergency Phone:**

Note: The administration of oral prescription medication during school or related activities on any day is subject to the school having sufficient and appropriate resources available that day for the safe use and administration of such oral prescription medication.

PART 1: TO BE COMPLETED BY ATTENDING PHYSICIAN	
This is to advise that I have prescribed the administration of the following oral medication which must be taken during school hours.	
Name of Medication:	**Method of Administration:**
Dosage:	**Time(s)**
How long is the child likely to need this medication?	
Possible hazards or side effects:	
Action to be taken should a reaction develop:	
Additional information if applicable (i.e. storage of meds, other allergies):	
Physician's Name (Print):	**Address & Phone:**
Physician's Signature:	
Date:	

PART 2: TO BE COMPLETED BY PARENT/GUARDIAN

- ☐ **I understand that I am responsible to provide the medication in its original prescription container supplied by the pharmacist, which is properly labeled indicating the student's name and administration directions.**
- ☐ **I request and authorize the principal or designated staff member to administer the medication according to the Physician's directions.**
- ☐ **I understand it is my responsibility to ensure the school has a supply of medication on hand at any given time, and to remove the medication at the end of the school year.**

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

PART 3: TO BE COMPLETED BY PRINCIPAL	
Staff member designated to supervise/administer medication:	**Alternate:**
Location of medication in the school:	
Signature of Principal:	**Date:**

The "Medication Administration Record" form must be run on the backside of this page.

MEDICATION ADMINISTRATION RECORD

School Year _____

Student's Name:	**Designated Staff Member:**
Medication:	**Alternate Staff Member:**
Dosage:	**Time of Administration:**

Initial each time that medication is administered.
Record abnormal or unusual circumstances related to the administration of the medication.

Date	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
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File in student Prevalent Medical Conditions folder with Plan of Care. Also file a copy in the OSR. Retain until superseded or no longer in effect.