
## Northeastern Catholic District School Board

## Authorization for Administration of Medication

Name of Student: _____ Date: _____

Address: _____ Telephone - Work: _____

_____ - Home: _____

School: _____ Name of Teacher: _____

**Note to Physician: Please indicate why medication must be administered at school**

**Physician's instructions for Administering Medication**

Name of medication: _____

Storage and safe keeping requirements: _____

_____

Dosage: _____ Frequency: _____

Method of administration: _____

_____

Dates for which authorization applies: _____

Possible side effects: _____

Other comments: _____

_____ _____

(Physician's Signature) (Please print name)

_____

(Physician's Telephone Number)


# Northeastern Catholic District School Board

## Parent/Guardian Authorization

We hereby request that the above medication and procedures as outlined by our Physician be administered to our child.

We understand that the Northeastern Catholic District School Board or its employees will not be legally responsible for the administration of oral medication.

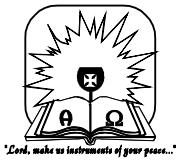
_____ _____

(Parent/Guardian's Signature) (Parent/Guardian's Telephone Number)

**NOTE: This request will expire June 30th of each school year.**

**The legal authority for the collection of this information is the Education Act. The Board uses the information for the purpose of carrying out its responsibilities under the Act. If you require clarification about the collection of information, contact the Freedom of Information Coordinator, at (705) 268-7443.**

## Northeastern Catholic District School Board




# School Record Form

**Administration of Medication to Students by Board Personnel**

Name of School: _____

Name of Pupil: _____

Name of Physician: _____ Telephone #: _____

Name of Parent/Guardian: _____ Business Telephone: _____

Home Telephone: _____

Name of medication: _____

**Method of Administration/Special Instructions**

_____

_____

_____

_____

_____

**Names of Persons Responsible for Administration of Medication**

_____ _____

_____ _____

| Dosage Given | Date | Time | Other | Signature or Initial |
|---|---|---|---|---|
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Principal's Signature

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