

HAMILTON WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- PHYSICIAN/NURSE PRACTITIONER FORM**

**Part I To be completed by the attending physician when medication is initiated or changed.**

(Please type or print)

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ School: \_\_\_\_\_

This is to advise that I have prescribed the administration of the following medication listed below for those days when the above-mentioned student is in school:

1. Name of Medication \_\_\_\_\_  
Method of Administration \_\_\_\_\_  
Dosage \_\_\_\_\_ Time(s) \_\_\_\_\_
2. Expected date of discontinuation: \_\_\_\_\_
3. Must the medication be taken during school hours? \_\_\_\_\_
4. Contra-indications to giving medication: \_\_\_\_\_
5. Please specify possible hazards or side effects of medication:  
\_\_\_\_\_  
\_\_\_\_\_
6. Action to be taken should a reaction occur: \_\_\_\_\_  
\_\_\_\_\_
7. Allergies which should be noted (if applicable): \_\_\_\_\_  
\_\_\_\_\_
8. Additional instructions (e.g., storage of medication, etc.):

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- ADULT STUDENT/PARENT/GUARDIAN FORM**

**PART II -To be completed by Adult Student/Parent/Guardian when medication is initiated, changed, and annually at the beginning of each new school year.**

This is to authorize the administration of the medication(s) prescribed by the attending physician/nurse practitioner from \_\_\_\_\_ to \_\_\_\_\_ for:  
date date

**Student's Name:** \_\_\_\_\_ **Birthdate: (yyyy/mm/dd)** \_\_\_\_\_

School: \_\_\_\_\_

Medic Alert I. D.: Yes \_\_\_\_\_ No \_\_\_\_\_

- I give permission for my child to self-administer the medication prescribed by the attending physician. Yes \_\_\_ No \_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_  
(Year, Month, Day)

- I release and agree to indemnify the Hamilton-Wentworth Catholic District School Board and its staff from any liability or damages incurred by any party as a consequence of the administration or lack of administration of medication to myself or my child.

Signature of Parent/Guardian/Adult Student: \_\_\_\_\_

Date: \_\_\_\_\_  
(Year, Month, Day)

**NOTE:**

- Parents/guardians/adult students are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS, preferably those in which the medication was supplied from the pharmacist/physician.
- The containers should be PROPERLY LABELLED indicating the NAME of MEDICATION, STUDENT'S NAME, AND ADMINISTRATION DIRECTIONS.
- The medication will be delivered by parent/guardian/adult student, according to an agreed schedule, to the Principal or designated person for safe keeping, unless otherwise determined.

In case of EMERGENCY, the contact persons are:

Name \_\_\_\_\_ Name \_\_\_\_\_

Telephone \_\_\_\_\_ Telephone \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Under The Municipal Freedom of Information and Protection of Privacy Act, 1989, information in forms and documents pertaining to a student registered/enrolled within The Hamilton-Wentworth Catholic District School Board is collected under the legal authority of The Education Act, and its Regulations, and the Ontario Student Record (O.S.R.) Guideline, 1989. This information is being collected to ensure that the educational program which is provided meets your child's needs.