UPPER CANADA DISTRICT SCHOOL BOARD

Authorization for Administration of Medication

Pharmacist Medication Information Sheet MUST be attached for all Prescription Medication

Note: All costs to have this form completed are the responsibility of parent(s)/guardian(s).
A new authorization form must be submitted each school year and whenever the medication is modified.

Name of Student		Birth Date
Teacher	Grade	Telephone

	Prescription Medication **** Prescription information below MUST match Prescription bottle** **** ALL medication must be received within pharmacy bottle**	**Over the Counter Medication** **** Must be in original packaging** ***Only Parent authorization is required for over the counter medication**
Name of medication and Dosage		
Amount to be given		
Frequency/times to be administered		
Purpose of medication (e.g. anxiety, pain, hyperactivity)		
Special Instructions (e.g. take with food)		
Physical Description of medication		
Period of time medication will be needed (if not ongoing).		
Anticipated reaction to medication (symptoms, side effects…) Please attach plan of action in case of emergencies		
Physician's Name		
Physician's Telephone #		
Signatures	**Physician signature required**	**Parent Signature**

Parent/Guardian's Approval

I hereby request and give permission for the school to administer medication prescribed herein to my child who is named above, for this school year only for the duration indicated. I recognize the administration of medication involves risks and unexpected consequences of the administration of medication may occur (including but not limited to illness, adverse reactions). By requesting and consenting to UCDSB staff administering medication the student, parent/guardian is assuming the risks of unexpected consequences. The student, parent/guardian and not UCDSB is solely responsible for the unexpected consequences arising out of the administration of the medication.

Parent/Guardian's Signature	Date

Creating Futures, Leading and Learning for All