fraser academy

ADMINISTRATION OF MEDICATION
2020-2021

Instructions

All health forms must be updated at the beginning of each school year. A new form is to be completed if the medication or dosage changes.

If you would like school personnel to administer medication to your son/daughter, please complete this form.

Section A is to be completed by the parent/guardian. Please print the form for your child's prescribing physician to fill out Section B.

Prescription medication cannot be given until this form is completed and returned to the school. Medication must be provided in a container with a label from the pharmacy. Many pharmacies can provide an additional labelled container upon request. Herbal and over-the-counter medication MUST be in the original, clearly labelled container.

Parents are responsible for checking expiry dates of medications and providing refills as necessary.

The school staff will keep a medication log for your child.

A. To be completed by parent or guardian

Student Name	Grade	Date of Birth (DD/MM/YYYY)

Parent or Guardian	Home Phone	Work Phone

Physician	Physician's Phone

Parent / Guardian Authorization

I request the school staff to give medications to my child as prescribed by my child's physician, **as listed on page 2 of this form**.

I will notify the school promptly of any changes in medications or medication dosages. I understand that I will need to have a new **Administration of Medication** form filled out by myself and my child's physician. If I wish to cancel the administration of medication, I will do so in writing.

I am aware that the school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith. I authorize the school to share this plan and it's information with any relevant staff, for the purposes of administering this child's medication. Information shared will be subject to the school's Privacy Policy.

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

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B. To be completed by prescribing physician

Student Name	Grade	Date of Birth (DD/MM/YYYY)

Name of Medication	Condition(s) Treated by Medication	Dosage	Directions for Use

Additional comments, possible reactions, and/or consequences of missing medication

Physician Authorization

Signature of Physician	Physician Name	Date (DD/MM/YYYY)

Physician's Address	Physician's Phone