ADMINISTRATION OF MEDICATION
2021-2022

Instructions

All medical forms must be updated at the beginning of each school year. It is your responsibility to submit a new form if the medication or dosage subsequently changes.

If you would like school staff to administer medication to your child, please complete this form.

Section A is to be completed by the parent/guardian. Have your child's prescribing physician 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.

School staff will keep a medication log for your child.

Section A. To be completed by parent or guardian

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

Parent / Guardian Authorization

I request the school staff to give medications to my child as prescribed by my child's physician, **as listed in Section B of this form**.

I will notify the school promptly of any changes in medications or medication dosages, by completing and submitting a new Administration of Medication form. If I wish to cancel the administration of medication, I will do so in writing, to **info@fraseracademy.ca**.

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 the information in this form with any relevant staff, for the purposes of administering my child's medication. Information disclosed on this form will be subject to the school's Privacy Policy.

Signature of Parent/Guardian 1	Parent/Guardian 1 Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian 2	Parent/Guardian 1 Name	Date (DD/MM/YYYY)

fraser academy

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Section B. To be completed by prescribing physician

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

The above named student can be administered the following medication(s) by school staff:

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

Additional comments:

Physician Authorization

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

Physician's Address	Physician's Phone