Bloorview SCHOOL AUTHORITY

ADMINISTRATION OF PRESCRIBED MEDICATION

To be completed when the school agrees with the parental request to administer medication during the school day. A new form must be completed:

(a) at the beginning of each school year
(b) when the dosage changes
(c) when a new medication is added

Sections A, B and C need to be completed. Only complete the second page of this form if more than one medication is required.

PLEASE NOTE: Medication must be in its original container with the pharmacy label on it, indicating the child's name, dosage, instructions for administration and expiry date.

A. TO BE COMPLETED BY THE PARENT

Student Name *(Last Name, First Name)*		D.O.B. *(dd/month/year)*	Gender ☐ M ☐ F
Address		Postal Code	
Student Home Phone #	Medic Alert I.D. ☐ Yes ☐ No	Teacher	
Name of Parent #1		Home Phone	Cell/ Business
Name of Parent #2		Home Phone	Cell/Business
Emergency Contact Person		Home Phone	Cell/Business

B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(For medication which MUST be taken during school hours or during school sponsored events; include instructions re storage of medication for refrigeration, etc.) ***If more than 1 medication, please see reverse for more space.***

Name of Medication	
Reason for Medication	
Method of Administration (*Dosage, time of administration*)	
Additional Instructions	
What is the impact of a missed dose?	
Name of Physician *(please print)*	Phone #
Signature of Physician	Date

C. TO BE COMPLETED BY THE PARENT/GUARDIAN

Student carries medication on his/her person: ☐ Yes ☐ No Information regarding safe transportation of medication:

_____

_____

I authorize and request the administration of the above medication from _____d/m/year_ to _____d/m/year_____

Signature of Parent/Guardian Date

Please turn over for page 2 . . .

ADDITIONAL MEDICATION

Complete the below sections for each **additional** medication to be administered.

B: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(For medication which MUST be taken during school hours or during school sponsored events; include instructions re storage of medication for refrigeration, etc.)

Name of Medication	
Reason for Medication	
Method of Administration (*Dosage, time of administration*)	
Additional Instructions	
What is the impact of a missed dose?	
Name of Physician *(please print*)	Phone #
_____ *Signature of Physician* Date	

C: TO BE COMPLETED BY THE PARENT/GUARDIAN

Student carries medication on his/her person: ☐ Yes ☐ No Information regarding safe transportation of medication:

_____

_____

I authorize and request the administration of the above medication from _____d/m/year__to _____d/m/year

Signature of Parent/Guardian Date

***See school website for Procedure: Administration of Medication**

PLEASE RETURN THIS FORM TO SCHOOL

Personal information contained on this form is collected pursuant to the *Education Act* and the *Municipal Freedom of Information and Protection of Privacy Act*. Questions about the collection and the use of this personal information should be directed to,

Bloorview School Human Resources, at 416 424-3831.