

AUTHORIZATION FOR ADMINISTERING MEDICATION

Part I: Student Information and Emergency Contacts

Student: _____		DOB: _____ (Yr/Mo/Day)
Address: _____ _____		Postal Code: _____
Home Phone: _____	Bus. Phone: _____ Cell Phone: _____ (Mother)	Bus. Phone: _____ Cell Phone: _____ (Father)
Parent(s)/Legal Guardian(s) Names _____		
Other Emergency Contact: _____		Phone: _____
Name/Relationship: _____		Cell Phone: _____
School: _____	Grade: _____	Teacher: _____

Authorization valid for school year : _____

Alberta Health Care Number: _____

Other Health Care Plans and Numbers: _____

Part II: PHYSICIAN'S INFORMATION

(Please attach a separate page for additional information)

1. Medical condition(s) requiring administration of medication:

2. Medication required:

3. Dosage to be given, frequency, and/or specific time of day:

4. Specify medication storage requirements, if any:

Continued

5. Prescription Duration:

From: (Yr/Mo/Day) _____ To: (Yr/Mo/Day) _____

6. Nature of reaction to allergen exposures, if any (check all applicable):

- Physical contact with this allergen may cause reaction
- Airborne contact with this allergen may cause reaction
- Ingestion of food may cause reaction
- Other _____

7. List possible reactions, including symptoms or side effects, to medication:

8. List possible symptoms or reaction if medication is missed:

9. Emergency procedure in event of reaction:

10. Specify medical facility/hospital and physician's phone number which can be called in the event of an emergency: (Name of Medical Facility):

Physician's Phone No.: _____ (include office and after hours emergency numbers)

11. Procedures to Follow to Administer Medicine: (The parent/legal guardian, in consultation with the attending physician, must provide specific procedures to the school or other designated individual authorized for the administration of medication.)

12. Location where medicine will be stored: _____

13. Individuals responsible for supervising student when they administer medication:

Acknowledgment by Parent(s)/Legal Guardian(s)/ Independent Student:

All reasonable action taken by staff, to administer medication and respond to possible reactions or emergencies, is both requested and authorized by me/us.

Parent/Legal Guardian Signature _____

Parent/Legal Guardian Signature _____

Date: (Yr/Mo/Day) _____

Independent Student Signature _____

The personal information on this form is collected under the authority of Alberta's *School Act* and *Freedom of Information and Protection of Privacy Act* (FOIP). The information contained herein will be treated in accordance with the privacy protection provisions of the FOIP Act. If you have questions concerning the collection, use, or disclosure of this information please contact the school principal either in writing or telephone.