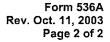


ADMINISTRATION OF PRESCRIBED MEDICATION

, 	☐ 140 Borough Drive Scarborough, M1P 41		ric Centre Court Coke, M9C 2B3	5050 Yonge North York,	
To be completed when the school agrees with the parental request to administer medication. A new form must be completed when the process is initiated or when medication changes. This form is to be filed at the school.					
A. TO BE COMPLETED BY THE PARENT					
Student Name (Last Name, First Name)			D.O.B. (dd/month/year)	Gender □ M □ F	Student #
Address			Postal Code] = 1.72 = 2.2	Health Card #
Student Home Phone #	Medic Alert I.D. ☐ Yes ☐ No	Teacher			Classroom #
Name of Father			Home Phone #		Business #
Name of Mother			Home Phone #		Business #
Name of Guardian		Home Phone #		Business #	
Emergency Contact Person Phone #				Phone #	-
B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN (For medication which MUST be taken during school hours or during school sponsored events (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					
I authorize and request the administration of the above medication from to to I will provide the medication in the original container with expiration date, labeled by a pharmacist.					
Signature of Parent/Guardian Date					
D. TO BE COMPLETED BY THE PRINCIPAL OR DESIGNATE					
Staff designated to supervise/administer medication					
Alternate(s)		-			
Location of Medication in th	e School				
Signature of Principal					Date

THIS FORM IS TO BE RETAINED BY THE SCHOOL



Date



B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN (For medication which MUST be taken during school hours or during school sponsored events (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? Phone # Name of Physician (please print) Signature of Physician Date B. TO BE COMPLETED BY THE ATTENDING PHYSICIAN (For medication which MUST be taken during school hours or during school sponsored events (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