Toronto District School Board

ADMINISTRATION OF PRESCRIBED MEDICATION

☐ 140 Borough Drive, Scarborough, M1P 4N6 ☐ 1 Civic Centre Court, Etobicoke, M9C 2B3 ☐ 5050 Yonge Street, North York, M2N 5N8

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		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 #	

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 _____
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 the School
Signature of Principal — Date

THIS FORM IS TO BE RETAINED BY THE SCHOOL

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	Date

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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