CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

2755 Highway 43, Kemptville, Ontario K0G 1J0
phone: 613-258-7757 toll free: 1-800-443-4562
www.cdsbeo.on.ca

Authorization for Administration of Medication

Student Information

Student Name: _____ DOB: _____ Age: _____ Grade: _____

OEN: _____ School: _____ Teacher: _____

Home Address: _____ City: _____ Postal Code: _____

Parent(s)/Guardian(s): _____ Contact Number: _____

Parent(s)/Guardian(s) must immediately notify the Principal or designate if administration of medication outlined in the Authorization for Administration of Medication form is not to occur on a given day. Such requests shall also be documented in the Student Medication Log.

Medication Information

Name of Medication: _____ Amount to be Given (e.g., mg): _____

Times of Administration: _____ Duration of Administration: _____

Possible Side Effects: _____

Physician's Address: _____ Contact Number: _____

Physician's Name: _____ Physician's Signature: _____ Date: _____

Please share any written documentation which would be helpful

Consent for Student to Carry and Self-Administer Anaphylaxis Medication

We agree that, _____ *(name of student)*

☐ Will carry their prescribed anaphylaxis medications/EpiPen on their person at all times
☐ Can carry their prescribed medications and delivery devices while at school and during school-related activities
☐ Can self-administer their prescribed medications and delivery devices while at school and during school-related activities
☐ Requires assistance with administering their prescribed medications and delivery devices while at school and during school-related activities.
☐ We will inform the school of any change in medication or delivery device. The medications cannot be beyond the expiration date.

Parent(s)/Guardian(s) Name: _____ Signature: _____ Date: _____

Designated Person Administering Medication

I, _____ *(print name),* agree to administer the medication herein requested by the parent(s)/guardian(s) as prescribed by the Physician and to maintain a log of such administration.

Signature of Medication Administer: _____ Principal's Signature: _____ Date: _____

Parent(s)/Guardian(s) Approval

Parent(s)/Guardian(s) Name: _____

Parent(s)/Guardian(s) Signature: _____ Date: _____

A new Authorization for Administration of Medication must be submitted each school year and whenever medication is modified.
Information Collection Authorization: This information is collected pursuant to the Board's education responsibilities as set out in the Education Act and is within guidelines set out in the Municipal Freedom of Information and Protection of Privacy Act, 1989. The information is collected for education purposes and will be used to meet student medical needs. This information will become part of the Ontario Student Record. Any questions with respect to this information should be directed to the School Principal.

Copies to: Parent(s)/Guardian(s) Ontario Student Record (OSR)