



NIAGARA CATHOLIC DISTRICT SCHOOL BOARD

**ADMINISTRATION OF PRESCRIBED AND NON-PRESCRIBED
MEDICATION DURING SCHOOL HOURS**

This information is being collected under the Authority of The Education Act, and will be used for the purposes of administering prescribed and non-prescribed medication during school hours. Questions about this collection should be directed to the Superintendent of Education,

A. TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student:	School:	Grade:
Date of Birth:	OEN:	
Name of Parent/Guardian:	Day Phone:	Cell:
Name of Parent/Guardian:	Day Phone:	Cell:
Name of Emergency Contact:	Phone:	Relationship:

Parent/Guardian Approval:

I hereby request and give permission to _____ School to administer the noted medication according to Board procedures and the instructions of the Physician/Medical Professional.

- I understand that I am responsible for providing the medication in its original pharmaceutical container and the original dispensed quantity of medication supplied by the pharmacist, which is properly labeled indicating the student's name and administration directions. I request and authorize the Principal/Designate to administer the medication according to the Physician/Medical Professional's directions. I understand it is my responsibility to ensure the school has a supply of medication on hand at any given time. Principal/Designate will return any remaining medication to the parent/guardian or take it to the local pharmacy for disposal at the end of the school year.

Signature of Parent/Guardian: _____ Date: _____

B. TO BE COMPLETED BY PHYSICIAN/MEDICAL PROFESSIONAL

This is to advise that I have prescribed the administration of the following medication which must be taken during school hours.

Name of Medication:	Dosage and Instructions Per Administration:
Diagnosis/Reason for Medication:	
Possible Side effects:	
Administration Dates: Start Date: _____ End Date: _____	Time(s) of day for administration:
Physician/Medical Professional Name, Address and Phone:	Signature of Physician/Medical Professional:

**NOTE: PLEASE RETAIN A COPY FOR THE DURATION OF THE STUDENT'S ATTENDANCE AT THE SCHOOL.
A NEW FORM MUST BE COMPLETED AT THE BEGINNING OF EACH SCHOOL YEAR, OR IF THE MEDICATION CHANGES.**