SUNRISE SCHOOL DIVISION

JLDC – E1

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIBED MEDICATION

(Prescription or over-the-counter)

This form is to be completed by the student's parent or legal guardian.

Student Identification

Name: _____

Date of Birth: _____

M.H.S.C. #: _____ P.H.I.N. # :_____

Home Phone: _____

Address: _____

Parent/Legal Guardian Identification

Name:

_____

Work Phone (Mother):

_____

Work Phone (Father):

_____

School Identification

Name of School: _____

Address: _____

Phone: _____

Physician Identification

Name:

_____

Address:

_____

Phone: _____

Emergency contact if unable to reach parent/guardian:

Name: _____ Phone: _____

Medication Information

Name of physician consulted: Phone: _____

_____

Name of pharmacist consulted: _____ Phone: _____

Name of medication: _____

Reason for medication: _____

Dosage and method of administration: _____

Approximate time(s) of administration during the school day: _____

Start date: _____ End date: _____

y/m/d *y/m/d*

Specific storage requirements:

_____

Side effects to watch for and actions required if these side effects are observed: _____

_____

Action required if medication missed: _____

Note: The first dosage of medication should be administered at home.

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(Prescription or over-the-counter)

Parent/Legal Guardian Authorization

(a) I understand that medications presented to a school not meeting the conditions of this procedure will not be administered by divisional staff. As the student's parent/legal guardian I retain full responsibility for administering the medication.
(b) I will provide a recent photo (school picture) of my child to the school.
(c) I am responsible for the delivery and supply of the medication (or will designate another adult to fulfill this responsibility).
(d) I understand that the medication container must have the dispensing instructions noted on it and must have the official label of the pharmacy. If requested, pharmacies will provide two original pharmacy-labeled containers.
(e) It is my responsibility to notify the school in writing of any changes in dosage or time of administration of medication.
(f) Only the school administrator (or designate) authorized by me is permitted to administer the prescribed medication.
(g) I understand that authorization automatically terminates June 30 of the current school year or upon change in medication.

I hereby request and authorize the school to administer the prescribed medication to my child. I have provided a recent photo (school picture) of my child. I also certify that the first dosage of the medication was given at home and was well tolerated. School personnel are authorized to contact the physician/pharmacist regarding any questions as to the administration of the medication.

_____ _____

Date *Signature of Parent/Legal Guardian*

FOR SCHOOL USE ONLY

Staff designate who will administer medication: _____
Date trained: _____ Training provided by: _____
Date: _____ Signature: _____
Alternate staff designate who will administer medication: _____
Date trained: _____ Training provided by: _____
Date: _____ Signature: _____

_____
Signature of Administration

Original authorization to be retained in student's file.

This authorization automatically terminates June 30 of the current school year or upon change in medication.

Cross Reference:		
Date Adopted: August 1, 2017	**Date Amended:**	**Board Motion(s):**
Procedure: JLDC	**Guidelines:** JLDC-R	**Exhibit:** JLDC-E2, JLDC-E3