MEDICAL CONDITION/MEDICATION AUTHORIZATION FORM

We are required by the Ministry of Education to have documentation on file if a student has a diagnosed medical condition that may require emergency care, an allergy producing an anaphylactic type response, and/or if the student is taking prescribed medication regularly, on a long-term basis.

Please have a physician sign PART A if any of the above applies to your child.

Complete PART B if either prescribed or over-the-counter medication is to be administered at school.

_______________________ _______________________ __________

Student First Name *Student Last Name* *Grade*

PART A

DIAGNOSIS (include allergies, conditions that may require emergency care and/or prescribed medication)

Name of Diagnosis/Allergy: ____

MEDICATION (If medication is to be administered at school please complete the authorization form (PART B) at bottom of this form. If an Epi-pen is required please complete the "Anaphylaxis Emergency Plan" on the reverse of this page.)

NAME OF ***PRESCRIBED*** MEDICATION(S)	DOSAGE	ADMINISTERED
		☐ at home ☐ at school
		☐ at home ☐ at school

By signing below I confirm that the medication noted above has been prescribed for my child by a physician.

_______________________________ _______________

Signature of Parent/Guardian *Date*

____

Name of Physician (please print)

_______________________________ _______________

Signature of Physician *Date*

PART B

COMPLETE THIS SECTION ONLY IF PRESCRIBED OR OVER-THE-COUNTER MEDICATION IS <u>TO BE ADMINISTERED AT SCHOOL</u>

Prescribed medication is to be provided in a properly labeled, original container from the pharmacy.

I hereby authorize school personnel to administer the prescribed medication noted above and/or the over-the-counter medication noted below.

I hereby consent to the storage of the medication noted above and/or below, and I understand that I must provide the school with that medication, and, if necessary, the equipment to administer the medication.

_______________________________ _______________

Signature of Parent/Guardian *Date*

CHECK ONE:

☐ Administer prescribed medication as described in PART A above. ☐ Administer over-the-counter medication as described below.

NAME OF ***OVER-THE-COUNTER*** MEDICATION	DOSAGE	REASON