OTTAWA CATHOLIC SCHOOL BOARD

Request and Consent for Administration of Medication

Name of Student: **School:** **Teacher:**

REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Student:		**Grade:**	
Parent(s)/Guardian(s):		**Telephone - Home:**	
Address:		**Telephone - Business:**	
		Telephone – Cellular:	
Physician's Name:		**Physicians Telephone:**	

PHYSICIAN'S STATEMENT FOR ADMINISTRATION OF MEDICATION

In my opinion, it may be necessary to administer medication during school hours:

1. Name of Medication: _____
2. Dosage and circumstances under which injection/medication to be administered: _____
3. Route of administration: (oral, inhalant, injection) _____
4. Frequency of administration: _____
5. Cautions or notable side effects: _____
6. Storage cautions, if any: _____
7. Additional information: _____

_____

Physician's Signature **Date:**

PARENT (S)/GUARDIAN (S) AUTHORIZATION

Name of Medication: _____ Prescription No: _____

Pharmacy: _____ Pharmacy Tel: _____

I am/We are the parent(s) guardian(s) of _____

I/We hereby request that the medication/procedure outlined above by my physician be administered to my/our child by the Ottawa Catholic School Board, its employees or agents; in consideration of the Ottawa Catholic School Board, its employees or agents agreeing to administer the medication/procedure outlined above, I/We do hereby release the Ottawa Catholic School Board, its employees or agents of any and all responsibility in connection with the administration of the said procedure, howsoever caused; and I/We do hereby agree to indemnify and save harmless the Ottawa Catholic School Board, its employees or agents from any legal responsibility for claims which may be made against /them or by any parent or guardian of my/our child who has not signed below, arising from the administration of the medication or procedure, howsoever caused.

I/We acknowledge that I/We have read the foregoing disclaimer and agreement to indemnify carefully, and do thoroughly understand the same.

I/We hereby acknowledge that the employees of the Ottawa Catholic School Board are not medically trained to administer medication. I/We acknowledge that I/We have reviewed the consequences and risks with the physician whose signature appears above, who has explained to me/us the warnings, precautions, reactions, and effects as represented by the manufacturer and/or supplier, and I/We acknowledge having understood

Parent(s)/Guardian(s) Signature(s) **Date: Month Day Year**

NOTE: This request will terminate either on the last day of each school year or when the prescription changes or expires. All medication must be in the original pharmacy container labelled by the pharmacist. If the student attends a summer school program, this request will terminate on the final day of the summer school program.

APPROVAL OF PRINCIPAL ***(NOTE: ALL INFORMATION TO REMAIN CONFIDENTIAL)***

Name of Principal		**School**:	
Signature of Principal:		**School Tel (613)** _____	
Date:		**School Fax (613** _____	

 Distribution: Student Medical File, OSR, parent(s), transportation authority

HEALTH AND SAFETY DEPARTMENT
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