Form 315-1

April 2003

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Student's Name _____Birthday _____ _____ _____
Year Month Day

Address_____

Phone Numbers: Home _____ Work (Mother) _____

Work (Father) _____ Legal Guardian _____

School Grade Teacher _____

Alberta Health Care Number _____

MEDICAL INFORMATION

Medication (name) _____

Prescription Number (if available): _____

Amount of medication sent to school _____

Prescribed daily dosage: _____

Required dosage to be given during school hours: _____

Frequency (specific time of day) _____

Duration (daily): From _____ To _____

Anticipated reaction (symptoms/side effects) _____

Emergency procedure in event of reaction _____

Name and phone numbers of prescribing physician in event of emergency_____

_____

PARENT'S REQUEST AND APPROVAL

I hereby request and give my permission to the above school to administer medication (including Epi-Pen, transportation to hospital and medical treatment at hospital for life threatening allergies) prescribed on this form to my child.

I agree to supply the medication in its original container that identifies the owner and contents. The supply will be replenished when necessary without contact by the school.

_____
Parent/Guardian (Please Print)

_____ _____
Parent/Guardian (Signature) Date