

Christ the Teacher Catholic Schools

ADMINISTRATION OF MEDICATION AUTHORIZATION FORM

I hereby request and authorize the administration of the following prescribed medication for my child _____ by non-medically trained staff at _____ school. IN CONSIDERATION of the Board permitting an employee of the Board to administer the said medication, I/we and each of us DO HEREBY RELEASE and forever discharge the Board and its employees from any liability or injury, illness, or disability suffered to _____ arising out of the administration of the said medication or from the failure to administer the said medication by an employee of the Board and DO FOREVER RELEASE the Board and its employees from any claims which I/we, or both of us, may have arising out of administration of the said medication or from the failure to administer the said medication to _____ .

I/we understand that a written statement, from the pupil's doctor, which supports the fact that the prescribed medication is of a type which can be safely administered by non- medical personnel, must accompany this request.

I/we understand that we are required to contact the school Principal, in writing, if there is a change in medication and/or dosage.

I/we understand that only daily medication requirements will be sent to school unless other arrangements have been made with the school principal.

I/we understand that we are to make special arrangements with the staff to handle emergencies on school excursions.

Parent/Guardian Signature: _____ Date: _____

Principal's Signature of Approval: _____ Date: _____

- Copy Principal (kept in the pupil's cumulative file)
- Copy Designated Administrator of Medication
- Copy Home Room or Classroom Teacher
- Copy Parent(s)/Guardians(s)
- Copy Student's Doctor