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) _____

Amount of medication sent to school _____

Dosage to be given _____ _

Frequency (specific time of day) _____ __

Duration (daily): From _____ To _____ _

Anticipated reaction (symptoms/side effects) _____

Emergency procedure in event of reaction _____

Locations of phone numbers of attending physician in event of emergency ____ __

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PARENTS 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 which identifies the owner and contents. The supply will be replenished when necessary without contact by the school.

_____ _____
Signature of Parent/Guardian Date Signed