



APPENDIX D

**AUTHORIZATION FORM FOR ADMINISTRATION OF MEDICATION TO STUDENTS  
BY PARENTS/GUARDIANS AND RESPONSIBLE DESIGNATES**

This form must be completed to advise school personnel that parents/guardians wish to administer medication to students during school hours or that parents/guardians or adult students wish to appoint a responsible designate to do so. The Medical Information Form must also be completed by the parent(s)/guardian(s) or the adult student. School personnel may not allow the administration of medication to students if the school has not received these completed forms.

The Principal shall consult with the parent(s)/guardian(s), responsible designate(s) and, where appropriate, the student, to develop a schedule for the administration of medication which is least disruptive to the student and other students and school personnel.

The Principal shall monitor the schedule and take appropriate steps to address any problems which arise. However, the responsibility for administration of the medication remains solely that of the parent(s)/guardian(s), responsible designate(s) or adult student. No records will be kept by school personnel of the administration of medication.

Copies of this form, and any schedule attached hereto shall be provided to: parent(s)/guardian(s) and/or, where appropriate, the student, the Principal and Board personnel to be designated by the Principal as required.

**A. Student Information**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_

School \_\_\_\_\_

Grade/Course \_\_\_\_\_ Teacher(s) \_\_\_\_\_

Home Telephone Number(s) \_\_\_\_\_ Parent's Work Telephone(s) \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Emergency Contact(s) & Telephone Numbers \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number(s) \_\_\_\_\_



## **B. Authorization of Parent(s)/Guardian(s)/Adult Student**

I/We am/are [the parent(s)/guardian(s) of] \_\_\_\_\_, a student at \_\_\_\_\_ School. I/We hereby advise that the medication specified in the Medical Information Form shall be administered by [me/us/or] [\_\_\_\_\_, who is/are hereby appointed as Responsible Designate(s)], to this student/me in accordance with this form, the Medical Information Form and any Schedule attached hereto with respect to the administration of medication. I/We understand and acknowledge that it is my/our responsibility to supply the medication, labelled as required by the Principal, and to provide information sufficient for a full understanding of any possible side effects and to address any concerns raised by the Principal.

I/we acknowledge that the responsibility for administration of the medication remains solely my/our responsibility and that of any responsible designate(s). I/we understand that no records will be kept by school personnel of the administration of medication.

I/We hereby acknowledge that this authorization will terminate automatically on June 30 of this school year, or earlier as specified in the Medical Information Form. I/We acknowledge that a new Authorization Form for Administration of Medication to Students by Parents/Guardians and Responsible Designates Form must be immediately completed if there is any change in the information contained therein.

I/We hereby acknowledge that the Near North District School Board (the "Board"), its agents or employees shall not be responsible for the administration of such medication, and I/we hereby release the Board, its agents and employees from all manner of actions, causes of action, suits, losses, damages or injuries, however caused, arising out of the administration of medication to this student/me, or failure on the part of any person to administer such medication or to administer such medication properly, and I/we do also hereby indemnify the said Board, its employees or agents for any losses or damages sustained by the Board as a result of such actions or proceedings being commenced against them by myself/ourselves, or any of this student's/my relatives, agents, sponsors or guardians.

I/We hereby acknowledge that I/we have read and fully understand the terms set out herein.

\_\_\_\_\_  
Parent/Guardian or Adult Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian or Adult Student Signature

\_\_\_\_\_  
Date

NOTE: The information gathered in this form is collected pursuant to the Education Act, the Municipal Freedom of Information and Protection of Privacy Act, related legislation and policies and the policies of the Near North District School Board. This information will be used to assist with meeting the health needs of the student. This form will be kept in the student's pupil records. If there are any questions about the information gathered on this form, please contact the Principal.

**RECEIVED BY PRINCIPAL**

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date