Rainbow District School Board

HEA-01

Physician's Authorization for the Administration of Medication

This form is to be completed and sent to the child's school.

TO BE COMPLETED BY THE PHYSICIAN

STUDENT NAME: ______________________ DATE OF BIRTH: __________

ADDRESS: ______________________ TELEPHONE #: __________

SCHOOL: ______________________ O.E.N.: __________

PHYSICIAN'S STATEMENT

This is to advise that I have prescribed the administration of medication listed below:

NAME OF MEDICATION: ______________________

METHOD OF ADMINISTRATION: ☐ Oral ☐ Injection

DOSAGE: __________ TIME(S): __________

How long is the child likely to need this medication(s)? __________

Must the medication be taken during school hours? ☐ Yes ☐ No

POSSIBLE HAZARDS OR SIDE EFFECTS OF MEDICATION (if applicable): __________

____

ACTION TO BE TAKEN SHOULD SUCH A REACTION DEVELOP: __________

____

ALLERGIES WHICH SHOULD BE NOTED (if applicable): __________

ADDITIONAL INSTRUCTIONS (if applicable): __________

____

PHYSICIAN INFORMATION

NAME: ______________________ TELEPHONE: __________

ADDRESS: ______________________

PHYSICIAN'S SIGNATURE: ______________________ DATE: __________

NOTE: This authorization will remain valid until there is a change in the prescription, but in no case, for longer than the current school year.

In accordance with Section 29(2) of the Municipal Freedom of Information and Protection of Privacy Act, personal information on this form is being collected under the authority of The Education Act and will be used for the purpose of providing emergency medical/hospital care and/or contacting the parent/guardian in the event of an emergency situation. Questions regarding this form should be directed to the principal.