Prairie South Schools 210 Learning together.
15 Thatcher Drive East, Moose Jaw, SK S6J 1L8 P 306 694 1200 F 306 694 4955 1-877-434-1200 prairiesouth.ca

CONSENT FOR MEDICATION ADMINISTRATION

As parent/guardian of _____, (the child), on behalf of myself as parent/guardian and on behalf of my child, I hereby request assistance from the staff of Prairie South School Division No. 210, the administration of medications of the child.

I recognize that such staff members do not have nursing, medical or pharmaceutical training.

I agree to provide the staff with a signed physicians order stating dosage and application schedule and will provide updated orders when the stated medication is changed in dosage or application schedule.

I hereby release Prairie South School Division No. 210 and its employees and volunteers from any responsibility for any error, injury or damage which may occur in connection with, or as a result of, the administration of medications, or the manner in which they are administered.

I further waive any claims that either I or my child may have against Prairie South School Division No. 210 and/or any of its employees or volunteers arising out of, or in connection with, or as a result of the administration of medications or in the manner in which they are administered, not withstanding that any such loss, injury or damage may have arisen in whole or in part, due to the fault or negligence of Prairie South School Division No. 210 and/or its employees or volunteers.

And, I agree that this waiver shall be binding upon both myself and my child and our respective heirs, executors.

I further acknowledge that I have been requested to execute this waiver in consideration of Prairie South School Division, agreeing to permit its staff to assist in the administration of medications to _____ (name of child).

Dated this _____ day of _____, 20___.

_____
Name of parent/guardian - **please print clearly**

_____ _____
Signature of parent/guardian Signature of witness

Student's Name: _____

NAME OF MEDICATION & DOSAGE: _____

DATE	TIME	MEDICATION GIVEN AND DOSAGE	SIGNATURE

Prairie South School Division No. 210

ADMINISTRATION OF MEDICATION FORM

Student Name: _____ Grade: _____

School Name: _____ Birthdate: _____

Parent(s)/Guardian(s): _____ Home Ph: _____

Home Address: _____ Work Ph: _____

REQUEST FOR AUTHORIZATION

I hereby request and authorize the administration of the following prescribed medication for my child by non-medically trained staff at _____ School.

_____ _____

Signature of Parent or Guardian Date

Student's Doctor: _____ Doctor's Phone Number: _____

Address of Doctor: _____ Signature of Student's Doctor: _____

Name of Student's Pharmacy: _____ Pharmacy's Phone Number: _____

Medication Prescribed	**Dosage**	**Times for Administration**	**Side Effects**

Other pertinent information:

Notes:

1. **Families/Agencies are required to contact the school principal if there is a change in medication and/or dosage.**
2. **It is expected that only the daily requirements will be sent to school unless other arrangements are made with the school principal.**
3. **It is recommended that all medications be blister packed. This can be requested when prescriptions are filled at any pharmacy.**

Copies: Principal; Designated Administrator of Medication; Home Room/Classroom Teacher; Student's Doctor