



## AUTHORIZATION FOR ADMINISTERING MEDICATION

Student Name (last, first, middle) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Grade in 2011-2012 \_\_\_\_\_

### Parental Consent

I give my permission for him/her to take the following prescribed medication while at Green Hedges School. I hereby acknowledge that I have read and understand the School's policies relating to the taking of medications as stated in the GHS handbook and on the reverse of this form. I hereby release Green Hedges School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the School to share information regarding this medication with the following licensed prescriber.

Parent/Guardian Signature \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Date \_\_\_\_\_

**PARENT OR GUARDIAN TO COMPLETE FOR OVER-THE-COUNTER MEDICATION.  
LICENCED PRESCRIBER MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS**

Child's Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Medications: \_\_\_\_\_

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again: \_\_\_\_\_

**Dates medication must be administered at school:**

Every day  Short term (List dates to be administered: \_\_\_\_\_)  Episodic/emergency events ONLY

Dosage to be given at School \_\_\_\_\_ time(s) or interval to be given: \_\_\_\_\_

**Possible adverse reactions:** \_\_\_\_\_

**Special handling instructions:**

Refrigerate  Keep out of sunlight  Other: \_\_\_\_\_

**Asthmatic/Diabetic ONLY**

This child is both capable and responsible for self-administering this medication:

NO  YES – Supervised  YES – Unsupervised

Licensed Prescriber's Name \_\_\_\_\_

Telephone Number \_\_\_\_\_ Emergency Number \_\_\_\_\_

Licensed Prescriber' Signature \_\_\_\_\_ Date \_\_\_\_\_