



## MEDICAL CONDITION/MEDICATION AUTHORIZATION FORM

We are required by the Ministry of Education to have documentation on file if a student has a diagnosed medical condition that may require emergency care, an allergy producing an anaphylactic type response, and/or if the student is taking prescribed medication regularly, on a long-term basis.

**Please have a physician sign PART A if any of the above applies to your child.**

**Complete PART B if either prescribed or over-the-counter medication is to be administered at school.**

\_\_\_\_\_  
*Student First Name*

\_\_\_\_\_  
*Student Last Name*

\_\_\_\_\_  
*Grade*

### PART A

**DIAGNOSIS** (include allergies, conditions that may require emergency care and/or prescribed medication)

Name of Diagnosis/Allergy: \_\_\_\_\_

**MEDICATION** (If medication is to be administered at school please complete the authorization form (PART B) at bottom of this form. If an Epi-pen is required please complete the "Anaphylaxis Emergency Plan" on the reverse of this page.)

NAME OF <u>PRESCRIBED</u> MEDICATION(S)	DOSAGE	ADMINISTERED
		<input type="checkbox"/> at home <input type="checkbox"/> at school
		<input type="checkbox"/> at home <input type="checkbox"/> at school

**By signing below I confirm that the medication noted above has been prescribed for my child by a physician.**

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Name of Physician (please print)*

\_\_\_\_\_  
*Signature of Physician*

\_\_\_\_\_  
*Date*

### PART B

**COMPLETE THIS SECTION ONLY IF PRESCRIBED OR OVER-THE-COUNTER MEDICATION IS TO BE ADMINISTERED AT SCHOOL**

**Prescribed medication is to be provided in a properly labeled, original container from the pharmacy.**

I hereby authorize school personnel to administer the prescribed medication noted above and/or the over-the-counter medication noted below.

I hereby consent to the storage of the medication noted above and/or below, and I understand that I must provide the school with that medication, and, if necessary, the equipment to administer the medication.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

**CHECK ONE:**

Administer prescribed medication as described in PART A above.    Administer over-the-counter medication as described below.

NAME OF <u>OVER-THE-COUNTER</u> MEDICATION	DOSAGE	REASON