

## ADMINISTRATION OF MEDICATIONS/MEDICAL INTERVENTIONS IN CCRSB

۹.	To be completed by F	arent / Guardian					
	Student Name:						
	Parent / Caregiver:	Phone (H)	(W)				
	Street Address:	*					
	School:		Grade				
	Emergency Contact:		Phone				
	I hereby request, authorize and empower the Chignecto-Central Regional School Board to administer medication or treatment as described herein to my child named above. I release any staff member and the Chignecto-Central Regional School Board from any legal liability that may result from the administration of such medication or the giving of such treatment. I also agree to indemnify the Chignecto-Central Regional School Board against claims at any time made arising out of the administration of medication or treatment described herein by my child or by MSI.						

Date: \_\_\_\_\_ Signature of Parent / Guardian: \_\_\_\_\_

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	<u>Medication</u>							
	Medication Prescribed		Dose	Duration	Time o Admin			
	Type of In-Sci	hool Interventi	on necessa	iry				
	Other: (medical interventions should be clearly stated in writing and attached to this release)							
,			×					
	<u>Considerations</u>							
	Type of storage required for medication							
	Possible side effects of medication(s) /treatment							
This medication can be safely administered by non-medical personnel.  OYes  ONo								
	Will it be detrimental to the child's healt	h if a single do	se/treatme	ent is omitted? ()	Yes O N			
			<b>,</b>					
	For school use only:		Sigr	nature of attending	physician			
	Date received:							
	Action taken:		Pho	ne Number				
	Personnel Involved:							

To be completed by Physician

В.