MED-01-02

ADMINISTRATION OF MEDICATIONS/MEDICAL INTERVENTIONS IN CCRSB

A. To be completed by Parent / 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: _____

B. To be completed by Physician

Medical condition requiring treatment

1. Medication

Medication Prescribed	Dose		Duration	Time of Admin.

Type of In-School Intervention necessary

2. Other: (medical interventions should be clearly stated in writing and attached to this release)

Considerations

(a) Type of storage required for medication

(b) Possible side effects of medication(s) /treatment

(c) This medication can be safely administered by non-medical personnel. ◯ Yes ◯ No

(d) Will it be detrimental to the child's health if a single dose/treatment is omitted? ◯ Yes ◯ No

For school use only:

Date received: _____

Action taken: _____

Personnel Involved: _____

_____
Signature of attending physician

_____
Phone Number

Please use Physician's stamp

☐ School Office File