CHRIS HADFIELD PUBLIC SCHOOL

Request For Administration Of Medication By Injection In Emergency Situations

Student: ______________________ Telephone#: ______________

Address: ____

Date of Birth: ____________ School: ______________ Grade: ____

Parent's Name: ________________ Bus. Phone #: ______________

PHYSICIAN'S INSTRUCTIONS FOR ADMINISTERING ORAL MEDICATION

(please type or print clearly)

Type of Allergy: ______________________________

Name of Medication: ______________________________

Dosage: ______________________________

Method of Administration: ______________________________

Dates for which authorization applies (length of time medication is to be given): ______________

Symptoms Indicating Emergency: ______________________________

Possible side effects: ______________________________

____

Special Storage and Safekeeping Requirements (if necessary): ______________________

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Physician's Name: ______________________________

Physician's Address: ______________________________

Physician's Telephone Number: ______________________________

Physician's Signature: ______________________________

PARENT/GUARDIAN AUTHORIZATION

►We hereby request that the above medication and procedure as outline by our physician be administered orally to our child.

Number of Epipens Supplied: ______

Where will they be located? (check applicable) : □ office (recommended) □ Classroom □ Student Carries

►We understand that the Durham District School Board and its employees will not legally be responsible for the administration of the medication.

►We understand that medication must be clearly labelled, in original packaging, not expired and delivered by an adult to the school office by the first day of school (or promptly after the prescription and request is implemented during the school year). This request will expire June 30 of each year.

Parent/Guardian Signature: ______________________________

Date: ______________________________