John McGivney CHILDREN'S CENTRE SCHOOL AUTHORITY	**REQUEST & AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL STAFF**	3945 Matchette Rd. Windsor, Ontario N9C 4C2 T: 519.977.2200 F: 519.977.2201 www.jmccentre.ca

PART 1. TO BE COMPLETED BY THE PARENT/GUARDIAN/STUDENT (if not a minor)

I request the John McGivney Children's' Centre School Authority to ensure that:

_____ _____

Name of Student D.O.B.

receive the medication prescribed by _____

Name of Physician

1. The medication provided must be supplied in the original prescription container, labeled with the name of the medicine, the physician's name, the amount to be taken and the time(s) to be taken, and the student's name. Prescription number: _____

2. This authorization must be signed by the student or, in the case of a minor, by the parent or legal guardian, whichever is the appropriate legal authority. In the case of a person who is disabled to such a degree as to be incapable to give consent, the next of kin may authorize the administration of medicine.

3. It is understood that the request is being made for school staff to undertake the administration of medicine, and that such staff are not medical professionals. The staff will make every effort to ensure that medication is administered in an appropriate manner, and at the times requested.

ACKNOWLEDGEMENT

I acknowledge that non-medical personnel are being asked to undertake the administration of medication or medical procedures to my son/daughter _____

I understand that there is some inherent risk in having non-medical personnel undertake the administration of medications and procedures, and accept the risks associated with this request.

Date: _____ Signature: _____

Parent/Guardian/Student (if not a minor)

Address: _____

Authorization for the collection of this information is in the Education Act. The information is used to assist JMCC SA in implementing health support services to students, including the administration of prescribed medication. Users of this information may be the principal, teachers, support staff, volunteers, bus operators and drivers. This form will be kept for a minimum period of one school year. Contact person concerning this collection is the principal.

PART 2. TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN

The following medication has been prescribed. It is necessary for this medication to be administered during school hours by personnel other than the parent/legal guardian.

<table>
<tr><td colspan="3">Name of Medication, Dosage, Method of Administration:</td></tr>
<tr><td colspan="3">Indications for Administration:</td></tr>
<tr><td colspan="3">Other Instructions:</td></tr>
<tr><td colspan="3">Cautions/Notable Side Effects:</td></tr>
<tr><td colspan="2">Period of Authorization:
From</td><td>To</td></tr>
<tr><td colspan="3">Prescribing Physician’s Name (please print)</td></tr>
<tr><td colspan="2">Address:</td><td>Telephone Number:</td></tr>
<tr><td>Date:</td><td colspan="2">Physician’s Signature:</td></tr>
</table>

NOTE: This form is valid until the prescription expires or is altered by the physician, whichever comes first. It is the responsibility of the parent/guardian/student to ensure that a new form is completed when required and returned to the school. Any cost associated with the completion of this medical request is the sole responsibility of the parent/guardian.

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