Northeastern Catholic District School Board

Authorization for the Administration of Medication	
Name of Student	
Date of Birth	
Name of Parent	
Address	
Telephone Contact	Home: Work: Mobile:
Name of School	
Name of Teacher	

NOTE TO PHYSICIAN: Please indicate why medication must be administered at school.

Name of Medication	
Storage and Safe Keeping Requirements	
Dosage	
Frequency	
Method of Administration	
Dates for which authorization applies	
Possible Side Effects	
Additional Information	
Name of Physician	
Physician's Contact Information	
Physician's Signature	

Parent Authorization

We hereby request that the above medication and procedures as outlined by our Physician be administered to our child. We understand that the Northeastern Catholic District School Board or its employees will not be legally responsible for the administration of oral medication.

Parent Signature: _____ **Date:** _____

Authorization must be completed at the beginning of each school year and/or every time that a prescription is modified and the oral administration of medications is required during school hours.

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