Turtle River School Division
Parents' request to give medication to a pupil

DATE:_____

PUPIL'S NAME:_____ DATE OF BIRTH:_____

PUPIL'S ADDRESS:_____

SCHOOL:_____

I/We acknowledge that the employees of Turtle River School Division are not medical people and have not been formally trained in administrating medication, and the Turtle River School Division, École Laurier, and the staff accept no liability for providing this service. I/We hereby release and forever discharge, and undertake and agree to indemnify and save harmless, Turtle River School Division and its employees of and from any and all claims of any kind whatsoever arising out of the administering of medication.

I hereby request and authorize that my child be given medication prescribed by our doctors or OTC medication. Such medication is to be given by the principal or his/her designate.

This authorization is considered to be valid until June 30 following this date, unless withdrawn by a parent. All unused medications are to be picked up on or before June 30. Any medication remaining after this point will be disposed of.

_____

_____
Signature(s) of Parent/Guardian

Please return to:_____

* Note: All information on the next page is to be completed by Parent/Guardian.

TURTLE RIVER SCHOOL DIVISION

École Laurier
C.P. 100
Laurier, Manitoba
R0J 1A0
téléphone (204) 447-2068 télécopieur (204) 447-3048

MECICATION INFORMATION

Name of Student:_____ Date of Birth:_____

Parents/Guardians:_____

Grade Placement:_____ Homeroom Teacher:_____

Medical Condition:_____

Name of Medication:_____

Name of Doctor:_____ Office Phone Number:_____

Emergency contact person during school hours:_____

Phone Number:_____

Alternate emergency contact person:_____

Phone Number:_____

Description of any "side effects" or other problems that may occur when this student is on this medication:

_____

_____

Comments:_____

_____

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"Learning today for tomorrow"

1. Name of child; date of birth; MHSC #; address; home telephone number:

_____

_____

2. Name(s) of parent(s)/ guardian(s); address; work telephone number; and home telephone
number:_____

_____

3. Name of prescribing physician; office address, and telephone number:

_____

4. Name of dispensing pharmacy; address, and telephone number:

_____

5. Name(s) of Medication(s):_____

6. Dosage and method of administration:_____

7. Time of administration during child's attendance in school:_____

8. Start date of medication:_____

9. Stop date of medication (if applicable):_____

10. Confirmation that the first dose was administered at home of hospital:

_____

11. Statement that the first dose was well tolerated by the child:

_____

12. Storage requirements, if any: _____

13. Description of side effects: _____

14. Response to side effects:_____

*** NOTE: Medication must be in original pharmacy labeled container.**