Lester B. Pearson School Board

Commission scolaire Lester-B.-Pearson

DORVAL ELEMENTARY SCHOOL

1750 Carson Avenue, Dorval, QC H9S 1N3
Tel.: 514-798-0738 Fax: 514-631-9006
Internet: http://dorval elementary.lbpsb.qc.ca

Request and Authorization For the Administration of Medication at School

********TO BE SUBMITTED ONLY IF YOUR CHILD REQUIRES MEDICATION AT SCHOOL********

Student's Last Name: _____ First Name: _____

Name of Parent/Guardian: _____

Address: _____ Date of Birth: _____

_____

_____ Grade _____

Home Phone: _____ Business Phone: _____

Physician's Name: _____ Tel: _____

Name of Medication: _____

The medication is to be:

- ☐ Self-administered by student under supervision of staff member.
- ☐ Administered to student by staff member designated by the principal.

Instructions: _____

_____

_____

_____

_____

Precautions to be taken in storing medication: _____

Prescription starting date: _____/_____/_____
Day Month Year

Prescription completion date: _____/_____/_____
Day Month Year

Parent's/Guardian's Signature: _____ Date: _____

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Release of Liability

For Administering Medication

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The undersigned _____, being the parents/guardians of _____, a student of the Lester B. Pearson School Board (Dorval Elementary School) do hereby request and authorize personnel employed by the Lester B. Pearson School Board to provide necessary medication to the said student, and for so doing, this will serve as a release and indemnification of and from any action or inaction of any personnel of the Lester B. Pearson School Board associated with the administering of medication to the said student. Further, the undersigned parents/guardians recognize and acknowledge that the personnel employed by the Lester B. Pearson School Board who may, as a result of this request, be administering medication to the said student, are not medical practitioners.

Dated at _____ (City), in the Province of Quebec,
this _____ day of _____ (Month) 20____.

Parent's/Guardian's Signature: _____

The medication must be submitted to the office in its original container. The medication will remain at school for the duration of time it is to be administered. Please indicate date(s) and time medication is to be given to your child:

Date: _____	**Time:** _____	**Date:** _____	**Time:** _____
Date: _____	**Time:** _____	**Date:** _____	**Time:** _____
Date: _____	**Time:** _____	**Date:** _____	**Time:** _____
Date: _____	**Time:** _____	**Date:** _____	**Time:** _____