ADMINISTERING MEDICATION

Authorization from the Parents

I authorize a member of the Greater Gatineau Elementary School staff to administer the following medication, as outlined in the attached physician's prescriptions to my child.

Student's Name: _____

Name & Description of Medication:

_____

_____

Physician's Name & Telephone Number:

_____

Dosage: _____

Time to be administered: _____

I take full responsibility for any possible effects of the above-mentioned medication, and I release and discharge the members or staff of the School, the School Board, the School Bus Contractor, and the Bus Driver of all responsibilities resulting from the administration of said medication to my child.

Parent or Guardian: _____ _____

(Signature) (Print Name)

Date: _____

Principal: Valerie Link Vice-Principal: Roxana Tiron-Baleanu

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