HURON-PERTH CATHOLIC
District School Board

Attending Physician's Authorization Form

Name of Child: School Year:

School: Date of Birth:

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1. Administration of Prescription Medication:

Select one of the following:
- ❑ Short term (under 6 weeks)
- ❑ Long term

Select one of the following:
- ❑ Must be administered by school personnel
- ❑ Must be supervised by school personnel when administered
- ❑ Self administers, no supervision required

Name of Drug: _____

Instructions for Storage: _____

Specific Directions for Administration:

2. Medical Condition of Child:

Physician's statement for health care assistance during school hours:

3. Emergency Response Plan for Condition:

Symptoms of reaction: _____

Recommended response to reaction:

Name of Physician (please print): _____

Telephone: _____

Signature of Physician: _____ Date:

Signature of Parent: _____ Date:

Personal information of the student and parent/guardian is being collected by the Huron-Perth Catholic District School Board in accordance with the *Municipal Freedom of Information and Protection of Privacy Act* to be used to provide education services pursuant to the *Education Act* s.170(1)7 and PPM 163 and the *Human Rights Code*, s.1.