WETASKIWIN REGIONAL PUBLIC SCHOOLS



"Inspiring students to become the best they can be."

FORM 315-1

AUTHORIZATION FOR ADMINISTERING PHYSICIAN PRESCRIBED MEDICATIONS

Parent must complete this form for any medication to be dispensed in school.

School:			
Student Name:			
Teacher:	Grade:		
Physician:	Phone:		
TO BE COMPLETED IN CONSULTATION WITH FAMILY PHYSICIAN:			
Name of Medication:	Possible Side Effects:		
Possible Side Effects:			
Data Oudanada			
Type of medication: tablet			
Special Considerations:			
Safety Precautions for Staff Administering:			
Name of Medication: Possible Side Effects: Date Ordered:	Termination Date:		
Type of medication: tablet			
Dose, Frequency & Time: Special Considerations:			
Safety Precautions for Staff Administering:			
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Options for Medication Administration (Check One):			
	Self – administration (unsupervised) as instructed by physician and parent		
	Self – administration (supervised by principal's designee) as instructed by parent		
	(Asthma, anaphylaxis – severe allergy attacks)		
Physic	cian's Name (Print):	Phone:	
Physic	siamla Ciamatuuna	Date:	
* Parent / Guardian Permission I request and give my permission to the School Principal or designee to administer the above medication(s) to my child It is understood that Wetaskiwin Regional Public Schools and the persons in its employ are absolved of all responsibility and liability relevant to this medication administration. I give permission for the principal to share with appropriate personnel information relative to the prescribed medicine administration as he/she determines necessary for my child's health and safety. I understand that I can retrieve the medication from the school at any time and that all medication must be picked up before the last day of school or following the termination of this order. If not picked up, all medication will be returned to the nearest pharmacy for proper disposal. I will provide the school with a written, revised statement signed by the physician if the information concerning the above prescription medication should change. In the event of our child experiencing anaphylactic medical emergency, I consent to the injection of epinephrine. I understand that in the event of our/my child experiencing a medical emergency, he/she will be transported to the hospital.			
Paren	t/Guardian Signature:	Phone:	
Admir	nistrator (or Designee) Signature:	Date:	
NOTE: Please return this completed form directly to the school or fax to 780-352-7886 and it will be directed to the applicable school.			

The personal information collected on this form is necessary for the School Division to operate educational programming and specialized learning services and will be entered into automated systems which support the efficiency of student services. This collection is authorized by Education Act and sections 4(a) and (c) of the Protection of Privacy Act. For questions about the collection of personal information, contact the Privacy Officer at www.wrps11.ca or 780-352-6018.

Revised: 9/17/2025