Prairie South Schools 210 Learning together.
1075 9th Avenue North West, Moose Jaw, SK S6H 1V7 P 306.694.1200 1.877.434.1200 F 306.694.4955 prairiesouth.ca

Authorization/Request for Administration of Essential Medication and/or Essential Procedures

As parent/guardian of _____, (the child), on behalf of myself as parent/guardian and on behalf of my child, I hereby request assistance from the staff of Prairie South School Division No. 210, the administration of :

Essential medications and/or essential procedures for my child.

_____
_____
_____
_____
_____

I recognize that such staff members do not have nursing, medical or pharmaceutical training.

I agree to provide the staff annually with a signed physicians order stating dosage and/or procedure schedule and will provide updated orders when the stated medication is changed in dosage and/or procedure schedule.

I hereby release Prairie South School Division No. 210 and its employees and volunteers from any responsibility for any error, injury or damage which may occur in connection with, or as a result of, the administration of essential medications and/or essential procedures, or the manner in which they are administered.

I further waive any claims that either I or my child may have against Prairie South School Division No. 210 and/or any of its employees or volunteers arising out of, or in connection with, or as a result of the administration of essential medications and/or essential procedures or in the manner in which they are administered, not withstanding that any such loss, injury or damage may have arisen in whole or in part, due to the fault or negligence of Prairie South School Division No. 210 and/or its employees or volunteers.

And, I agree that this waiver shall be binding upon both myself and my child and our respective heirs, executors.

I further acknowledge that I have been requested to execute this waiver in consideration of Prairie South School Division, agreeing to permit its staff to assist in the administration of essential medications and/or essential procedures to _____ (name of child).

Dated this _____ day of _____, 20___.

_____
Name of parent/guardian - **please print clearly**

_____ _____
Signature of parent/guardian Signature of witness

Student's Name: _____

This form must be completed and kept in the school office each time medication is provided. Add additional pages as needed.

NAME OF MEDICATION & DOSAGE: _____

DATE	TIME	MEDICATION GIVEN AND DOSAGE	SIGNATURE