Centre intégré
de santé
et de services sociaux
de Lanaudière
Québec

L N 0 6 9 5

AUTHORISATION FOR DISTRIBUTION
ADMINISTRATION OF MEDICATION (SCOLAIRE)

Installation : _____

Surname, First name : _____ File no : _____

Address : _____

Telephone # 1 : _____ Telephone # 2 : _____

Date of birth (yyyy/mm/dd) : _____ School : _____

All medication must be properly identified with a medical prescription code and the following information must appear on the medication package : name of the person medication is prescribed for, name of the medication, reason for administration, dosage, date of expiration and name of the doctor prescribing the medication.

I, _____ responsible for _____
(parent or tutor) (name of student)

Authorize the school principal or his representative at school (school personnel, child care services (CCS) or any other contributor providing services in school), to distribute / administer the following medications and to give this form to the school nurse :

Name of medication :	1)		2)	
Reason for distribution/administration :				
Time period for distribution / administration : From_____ to _____	❒ CCS ❒ School ❒ Regularly ❒ **In an emergency** ❒ As needed *(Référer à l'infirmière)*		❒ CCS ❒ School ❒ Regularly ❒ **In an emergency** ❒ As needed	
Dosage :				
Method of administration *(Consult school nurse if medication must be administered by **injection** or if medication required during an **emergency situation**)*	❒ By mouth ❒ Nose ❒ On skin (cream) ❒ Eyes: ❒ right ❒ left ❒ Ears : ❒ right ❒ left ❒ Inhalation ❒ **Injection**		❒ By mouth ❒ Nose ❒ On skin (cream) ❒ Eyes: ❒ right ❒ left ❒ Ears : ❒ right ❒ left ❒ Inhalation ❒ **Injection**	
Time (hh :mm) :				
Refrigeration :	❒ Yes	❒ No	❒ Yes	❒ No
Taken on professional days :	❒ Yes	❒ No	❒ Yes	❒ No
Known side effects :				
Parent or tutor's signature:				
Date (yyyy/mm/dd) :				