ADDENDUM B

Lester B. Pearson School Board
Request and Authorization for the Distribution of Medication at School

Name of Student: _____ _____
Last Name First Name

Name of Parent/Guardian: _____

Address: _____
_____
_____

Tel: (Residence) (____) _____ Tel: (Work Place) (____) _____
Area Code Area Code

Tel: (Cell) (_____)_____
Area Code

Physician's Name: _____ Tel: (____) _____
Area Code

Name of Medication: _____

The medication is to be:

- θ Self-administered by student under supervision of staff member.
- θ Distributed to student by staff member designated by the principal.
- θ Carried and self-administered

Instructions: _____
_____
_____
_____

Precautions to be taken in storing medication: _____

Prescription Starting Date: _____
Day Month Year

Prescription Completion Date: _____
Day Month Year

Parent's/Guardian's Signature: _____ Date: _____

THIS FORM IS VALID ONLY UNTIL COMPLETION OR ONE YEAR FROM THE STARTING DATE

ADDENDUM C

Form II

Lester B. Pearson School Board

Release of Liability
For Distribution of Medication

The undersigned_____, being the parents/guardians of _____, a student of the Lester B. Pearson School Board do hereby request and authorize personnel employed by the Lester B. Pearson School Board to provide necessary medication to the said student, and for so doing, this will serve as a release and indemnification of and from any action or inaction of any personnel of the Lester B. Pearson School Board associated with the distribution of medication to the said student. Further, the undersigned parents/guardians recognize and acknowledge that the personnel employed by the Lester B. Pearson School Board who may, as a result of this request, be distributing medication as indicated on the Prescription Label, to the said student, are not medical practitioners.

Dated at _____, in the Province of Quebec,

this _____day of _____ 20___.

Parent's/Guardian's Signature: _____

ADDENDUM D

Form III

Lester B. Pearson School Board

Medication Log

Student Name: _____ First Name: _____

Address: _____ Date of Birth: _____

School: _____

Grade: _____

Parent: _____ Home Tel: _____ Bus Tel: _____

Cell Tel: _____

Physician: _____ Tel: _____

Medication	Amount Distributed	Date	Time	Initials of Person Providing Service