Halton District School Board

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION BY STUDENT

TO BE COMPLETED BY PARENT/GUARDIAN

and

PRESCRIBING REGULATED HEALTH CARE PROVIDER

This Form is to be completed by a parent/guardian in order to request authorization for a student to self-administer a prescription medication while at school or at a school sponsored event.

A new Form 2 must be submitted whenever there is any change to the student's medication(s), and before the start of each school year.

This request will only be considered if:

(a) the medication is prescribed by a regulated health care provider;

(b) the administration of a prescribed medication on either a routine or emergency basis is necessary for the student to attend school or a school sponsored event; and

(c) it is appropriate for the student to self-administer the prescribed medication.

To be Completed by Parent/Guardian

Name of Student: _____ Name of School: _____

Name of Parent/Guardian: _____

Address: _____

_____

Home Telephone: _____ Daytime Telephone: _____

Cell Phone: _____ _____

Student's Date of Birth: Year _____ Month _____ Day _____

Student's Grade: _____ How and where will medication be stored at school:

Contact in Case of Emergency:

1. Name: _____ Telephone: _____

2. Name: _____ Telephone: _____

Name of Physician: _____ Telephone: _____

Physician's Office Address: _____

In submitting this request, I/we acknowledge and agree that:

(a) If the student's medication is to be stored at school, I/we are solely responsible for providing the prescribed medication in an adequate supply for up to two weeks. Some medications can not be stored at school. (Please consult the school administration regarding the appropriate student health protocol)

(b) Any medication will be provided in the original container(s) from the pharmacist, which will clearly display:

(i) the name of the student,

(ii) the name of the medication,

(iii) the dosage,

(iv) the name of prescribing regulated health care provider,

(v) frequency of administration, and

(vi) date of expiry.

(c) A copy of the pharmacist's instruction for the administration of the prescribed medication will be provided and shall include any general and specific information regarding possible side effects and the appropriate response should the student show any signs of such side effects.

(d) Because I/we are giving our permission for the student to self-administer the medication, I/we acknowledge and agree that school staff will not be designated or trained to administer the medication.

(e) I/we will immediately notify the Principal of any change to the student's medication(s), and will forthwith complete a revised Form 2.

(f) I/we acknowledge and agree that the personal information provided on this Form will be disclosed as necessary to school board and Transportation Consortium personnel.

I/we further hereby release the Halton District School Board, its employees and agents from any liability for loss, damage, illness or injury, howsoever caused to my/our child's person or property, or to me/us as a consequence, arising from the above-named student self-administering the medications identified in this Form and/or provided to the school.

_____ _____

Parent/Guardian signature Date

To be Completed by Prescribing Regulated Health Care Provider

Condition(s) for which this medication is required: _____

Method of Administration: _____

What is the expected result of administering the medication: _____

List any indicators that the medication should not be administered: _____

_____

List any indicators that the student has had an adverse reaction to the medication: _____

_____

In your opinion, is the student able to self-administer the prescribed medication? _____

_____ _____

Signature of Prescribing Regulated Health Care Provider Date

The personal and/or health related information gathered on this form is being collected, retained, used and disclosed in accordance with the *Municipal Freedom of Information and Protection of Privacy Act*, *Education Act* and *Personal Health Information Protection Act*, for the purpose of administering medication.

For School Use Only:

Date Received: _____ Indicate if Approved: _____

Personnel Designated to Administer Prescribed Routine Medication:

_____

Pharmacy Instructions Received?

_____

Principal's Signature: _____