HALTON CATHOLIC DISTRICT SCHOOL BOARD

MEDS. 2-NP (June 2015)

HALTON CATHOLIC DISTRICT SCHOOL BOARD

REQUEST AND CONSENT FOR THE ADMINISTRATION OF
NON-PRESCRIPTION MEDICATION

DATE (yy/mm/dd): _____

This form is completed when the school agrees with the parental request to administer oral medication. A new form is required: a) at the initiation of this process; b) at the beginning of each school year; c) when medication changes. Staff agreeing to administer medication will do so according to the information in this form only.

A. To be completed by the Parent/Guardian (please print)

STUDENT NAME:			**ADDRESS/ POSTAL CODE:**	
Date of Birth (dd/mm/yy)		**Gender: M☐ F☐**	**Student #:**	
Grade:	**Room:**	**Teacher:**		**Medic Alert I.D.? Y☐ N☐**
Name of Father:		Home Tel.#	Bus. Tel. #	Cell Tel. #
Name of Mother:		Home Tel.#	Bus. Tel. #	Cell Tel. #
Name of Guardian:		Home Tel.#	Bus. Tel. #	Cell Tel. #
Emergency Contact:		Home Tel.#	Bus. Tel. #	Cell Tel. #

B. To be completed by the parent/guardian (please sign at the bottom)

Statement of Understanding

Regarding Parent Requests to Provide Non-prescription Medication to Students by Employees of The Halton Catholic District School Board.

As the parent(s)/guardian of (print name of student) _____, I (we) accept and endorse the following five terms and/or conditions pertaining to my (our) request for Halton Catholic District School Board employees to provide, under our own authority, my (our) child with the medications listed in Part C of this form. Specifically, I/we understand and accept that:

1. I/we are responsible for safely delivering to and retrieving from school, any and all medications to be provided to my/our child. This commitment addresses the importance of reducing the possible loss of medications that are potentially harmful to other students;
2. Board employees are not trained health professionals and, hence, may not recognize the symptoms of my (our) child's illness or medical condition or know how to treat the illness or medical condition;
3. I/we are responsible for maintaining a limited but adequate supply of the medications noted in Part C;
4. Medications supplied to the school will be in original, clearly labeled containers which display:
    a) The proper dosage; b) time of administration; c) the name of the prescribing doctor; and
    d) The duration of the prescription.
5. I/we are responsible for providing up-to-date information to the school regarding changes in the medical condition or illnesses treated by the medicines noted in Part C, as well as changes in the prescription or administration routine.

Signature of Parent /Guardian: _____

C. To be completed by a parent/guardian

(For oral medications to be taken during school hours or school-sponsored events.)

MEDICATION	*Dose*	*PROVIDE @ (TIME)*	*REASON*
1.			
2.			
3.			
4.			

Additional instructions as needed: _____

D. To be completed by the parent/guardian.

Request and Consent for the Administration of Non-Prescription Medication

Insofar as it concerns my child (print child's full name) _____
a student attending (Print school name)_____, I/We:

I. **Have read and understand the information conveyed in this "Request and Consent for the Administration of Non-Prescription Medication" form;**
II. **Agree to comply with the responsibilities described in Part B above;**
III. **Request that the medications listed in Part C of this form be administered to my/our child according to the information we have provided; and furthermore,**
IV. **Release the Halton Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering, failing to administer correctly, or failing to administer at all, the medications named in Part C above.**

Signature of Parent/Guardian: _____

Date: _____

Personal information, as defined by the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) is collected under the authority of the Education Act, and in accordance with the provisions of MFIPPA. Personal information on this form will be used for the purpose of the administering non-prescription medication to your child/ren, and the tracking of. If you have questions about this collection; use, and disclosure of this information, contact the Manager, Privacy, Records and Information Management at 905.632.6314 x233 privacy@hcdsb.org