HALTON CATHOLIC DISTRICT SCHOOL BOARD

MEDS. 2-P (June 2015)

HALTON CATHOLIC DISTRICT SCHOOL BOARD

STAFF CONSENT FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

Name of Student _____

Name of Procedure _____

(Please indicate prescription number)

Date _____

NOTE: The administration of this medication will cease June 30th of each school year or when the medication is no longer required, as specified in **Meds. 1-P**, whichever comes first.

PRIMARY RESPONSIBLE PERSON FOR ADMINISTERING PRESCRIBED MEDICATION

1. **I have agreed to administer the prescribed medication herein requested by the parent or guardian according to the stipulations laid out in the current valid form MEDS. 1-P.**

_____ _____
(Date) (Signature)

_____ _____
(Date) (Signature)

ALTERNATE RESPONSIBLE PERSON(S) FOR ADMINISTERING PRESCRIBED MEDICATION

2. **Alternate person(s) agreeing to administer the prescribed medication when the Primary Responsible Person is unavailable:**

_____ _____
(Date) (Signature)

_____ _____
(Date) (Signature)

Distribution: 1. Attach to appropriate forms 2. O.S.R. 3. Health Care Binder

This information is collected pursuant to s. 170 and s.265(1)i) of the *Education Act*, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31, 32 and 33 of the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M-56 and the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sch. A.
If you have any questions regarding your child's personal information please contact the Principal of your child's school.