

HALTON CATHOLIC DISTRICT SCHOOL BOARD
Parent/Guardian Request and Consent for the Administration of
Prescription Medication

DATE (yy/mm/dd): _____

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

To Be Completed by the Parent/Guardian (please print)

A. Student Information

| | | | | | |
|--|-------|---|-----------------------|--|---|
| Student name: | | | Address/ Postal Code: | | |
| Date of Birth (dd/mm/yy) | | Gender: M <input type="checkbox"/> F <input type="checkbox"/> | Student #: | | Medic Alert I.D.? Y <input type="checkbox"/> N <input type="checkbox"/> |
| Grade: | Room: | Teacher: | | | |
| 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. # |
| Physician Contact: (please include names and numbers for all supervising physicians) | | Name: Bus. Tel. # | Name: Bus. Tel. # | | Name: Bus. Tel. # |

B. Indicate Oral Medications That Must Be Taken During School Hours or School-Sponsored Events. (please print)

| Medication | Dose | Provide @ (time) | reason | Physician's name |
|------------|------|------------------|--------|------------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

| Medication | Prescription | | Impact of missed dose? | observable side effects and response |
|------------|--------------|----------|------------------------|--------------------------------------|
| | Start Date | End Date | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Additional instructions as needed:

C. Statement of Understanding and Consent (signature required)

Statement of Understanding and Consent

Regarding Parent/Guardian Requests to Provide Prescribed Medication to Students by Employees of the Halton Catholic District School Board.

Insofar as it concerns my/our child (print child's full name) _____

a student attending (Print school name) _____, I/We:

accept and endorse the following terms and/or conditions pertaining to my (our) request for Halton Catholic District School Board employees to provide my (our) child with the medications listed in Part B of this form and prescribed under the authority and supervision of the doctor also named in Part A 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 prescription medications to be provided to my 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 providing and maintaining a limited but adequate supply of the medications noted in Part B;
4. Medications supplied to the school will be in original, clearly labeled containers which display:
 - a) Medication name;
 - b) the proper dosage;
 - c) time of administration;
 - d) the name of the prescribing doctor; and
 - e) the duration of the prescription.
5. I/we are responsible for providing up-to-date information to the school regarding the medical condition or illnesses treated by the medicines noted in Part B, as well as changes in the prescription or administration routine.
6. I/we request that the medications listed in Part B of this form be administered to my child according to the prescription information provided by the prescribing physician; and furthermore,
7. I/we acknowledge that I/we are aware and understand my/our child's medical condition and the risks associated with its care and emergency treatment, that the Halton Catholic District School Board and its staff and volunteers are acting in their role as educators and not health professionals, and that there is a risk of loss, damage, and injury to my child, including death, or to my property in the possession of my child, as a consequence of administering the interventions, failing to administer the interventions or failing to correctly administer the medications named in Part B above.

Having read and understand the information conveyed in this "Request and Consent for the Administration of Prescribed Medication" form;

I/we agree to comply with the responsibilities described above.

Signature of Parent/Guardian: _____ Date: _____

This information is collected under the authority of the Education Act, and Sabrina's Law and managed in accordance with the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. Information will be used in the case of a medical emergency. If you have questions regarding the collection, use or disclosure of this information, please speak to your school Principal.