HWDSB

Appendix F

AUTHORIZATION OF ADMINISTRATION OF ORAL PRESCRIPTION MEDICATION

A new form must be completed at the beginning of each school year, or when the medication changes. This form is to be retained until the end of the school year.

Student's Name:	**School:** **Class:** **Room:**
Date of Birth:	**Home Phone:** **Business Phone:**
Emergency Contact Name and Relationship to Student:	**Emergency Phone:**

Note: The administration of oral prescription medication during school or related activities on any day is subject to the school having sufficient and appropriate resources available that day for the safe use and administration of such oral prescription medication.

PART 1: TO BE COMPLETED BY ATTENDING PHYSICIAN

This is to advise that I have prescribed the administration of the following oral medication which must be taken during school hours.

Name of Medication:	**Method of Administration:**
Dosage:	**Time(s)**
How long is the child likely to need this medication?	
Possible hazards or side effects:	
Action to be taken should a reaction develop:	
Additional information if applicable (i.e. storage of meds, other allergies):	
Physician's Name (Print):	**Address & Phone:**
Physician's Signature:	
Date:	

PART 2: TO BE COMPLETED BY PARENT/GUARDIAN

- ☐ **I understand that I am responsible to provide the medication in its original prescription container supplied by the pharmacist, which is properly labeled indicating the student's name and administration directions.**
- ☐ **I request and authorize the principal or designated staff member to administer the medication according to the Physician's directions.**
- ☐ **I understand it is my responsibility to ensure the school has a supply of medication on hand at any given time, and to remove the medication at the end of the school year.**

Signature of Parent/Guardian:	**Date:**

PART 3: TO BE COMPLETED BY PRINCIPAL

Staff member designated to supervise/administer medication:	**Alternate:**
Location of medication in the school:	
Signature of Principal:	**Date:**

The "Medication Administration Record" form must be run on the backside of this page.

HWDSB

Appendix G3

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the _____ (school board) as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT
Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____ to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT
Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Name of Physician: _____ Physician Phone #: _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:
Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the _____ (School Board) through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

❒ classroom ❒ staffroom ❒ lunchroom ❒ other

❒ office ❒ school bus ❒ gym

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

❒ Food service providers ❒ Child care providers

❒ Board approved transportation carriers ❒ Other _____

❒ School volunteers in regular direct contact with my child

Signature of Parent/Guardian:_____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Signature of Principal: _____ Date: _____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

File in student Prevalent Medical Conditions folder with Plan of Care. Also file a copy in the OSR. Retain until superseded or no longer in effect.