 Code: C009

 Program

**Appendix B**

**Form A**

**Administration of Prescribed Medication to Students**

**To Be Completed by Parent/Guardian**

|  |  |
| --- | --- |
| **Student Information:** |  |

|  |  |
| --- | --- |
| **Student Name:** |  |
| **School:** |  |
| **Grade:** |  |
| **Home Address:** |  |
| **Classroom/Homeroom Teacher** |  |

|  |
| --- |
| **Emergency Contacts:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Phone Number(s): |  |
| Name: |  | Phone Number(s): |  |
| Name: |  | Phone Number(s): |  |

I hereby request, authorize and empower the Halifax Regional Centre for Education to administer medication as described herein to the student named above. I release any staff member and the Halifax Regional Centre for Education from any legal liability that may result from the administration of such medication. I also agree to indemnify the Halifax Regional Centre for Education against claims at any time made by the student name or by MSI arising out of the administration of medication described herein. I also understand that no more than two weeks dosage of the medication(s) is to be in the school at any time and that I am responsible for completing this form in the event that the prescribed medication, amount or frequency of dosage, handling or storage requirements change.

I acknowledge and understand that as a parent or guardian I am responsible to ensure there is medication in sufficient amount and dosage to meet the needs of the student every day the student is in school and requires the medication to be administered. I also understand and agree that if there is insufficient medication at the school I will be contacted to make arrangements to transport new medication to the school, or to make alternate arrangements for the care of the student for the remainder of the school day. I hereby release any staff member in the Halifax Regional Centre for Education from any legal liability that may result from insufficient amounts of medication being available at the school for administration to the student."

If my child is bussed to school, I also understand that I must provide a current photo of him/her for the purpose of providing all information contained herein to the transportation provider.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent/Guardian Name (Please Print) |  | Parent/Guardian Name (Please Print) |

|  |  |  |
| --- | --- | --- |
| Date: |  |  |

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**Form A**

**To Be Completed By Parent/Guardian**

|  |  |
| --- | --- |
| Student Name: |  |

|  |  |
| --- | --- |
| Name of medical condition(s) requiring medication to be given during school hours: |  |

|  |
| --- |
| **Note: Where possible Parent(s)/Guardian(s) are asked to establish a schedule for the administration of medication outside of the school day.** |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Medication #1 | Medication #2 | Medication #3 |
| **Name of Medication** |  |  |  |
| **Brief Description of Medication**, Ex: Heart Medication |  |  |  |
| **High Alert (Please circle)** |

|  |  |  |
| --- | --- | --- |
| Yes |[ ]   | No |[ ]

 |

|  |  |  |
| --- | --- | --- |
| Yes |[ ]   | No |[ ]

 |

|  |  |  |
| --- | --- | --- |
| Yes |[ ]   | No |[ ]

 |
| **Required Intervention** | [ ]  Administered by Staff[ ]  Self-administer with staff monitoring | [ ]  Administered by Staff[ ]  Self-administer with staff monitoring | [ ]  Administered by Staff[ ]  Self-administer with staff monitoring |
| **Dose of Medication**, Ex: mg/ml/#of tabs/amount |  |  |  |
| **Frequency** |  |  |  |
| **Time(s)** Medication to be given during school hours |  |  |  |
| **Possible side effects(s) of medication** |  |  |  |
| **Course of action in response to side effect(s)** |  |  |  |

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**Form A**

**To Be Completed By Parent/Guardian**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Medication#1 | Medication#2 | Medication#3 |
| **Route** |  |  |  |
| **Special Handling of Medication** |  |  |  |
| **Extra Comments** |  |  |  |
| **Storage requirements for medications** |  |  |  |
| **Duration of treatment**(Start -Finish) |  |  |  |
| **Date when first prescribed** |  |  |  |
| **Symptoms of overdose and suggested course of action** |  |  |  |
| **State course of action in the event of a missed dose** |  |  |  |
| **For feeding tube medications only****The amount of water to be flushed through the feeding tube** |

|  |  |  |
| --- | --- | --- |
| Before med: |  | ml |

|  |  |  |
| --- | --- | --- |
| After med: |  | ml |

 |

|  |  |  |
| --- | --- | --- |
| Before med: |  | ml |

|  |  |  |
| --- | --- | --- |
| After med: |  | ml |

 |

|  |  |  |
| --- | --- | --- |
| Before med: |  | ml |

|  |  |  |
| --- | --- | --- |
| After med: |  | ml |

 |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent/Guardian |  | Date |