FORM 1: REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER PRESCRIBED MEDICATION

Form 1 is to be completed by a parent/guardian, in consultation with a regulated health professional, in order to request that school personnel administer a prescribed medication to a student during school hours or during an approved school trip.

Form 1 must be reviewed annually and, if there are no changes to the prescription and the administration of the medication, an updated parent/guardian signature (Appendix C) is required. A new Form 1 must be submitted whenever there is any change to the student's medication(s).

A. To be Completed by Parent/Guardian (please print):

Name of Student:		Student's Date of Birth:	
Name of Parent/Guardian:			
Address:			
Home Telephone:		Daytime Telephone:	
Cell Phone:		Email:	

Contact in Case of Emergency:			
1. Name:		Telephone:	
2. Name:		Telephone:	

Prescribing Physician Information:			
Name:		Telephone:	
Physician's Office Address:			

B. If medication is only to be administered in the event of an emergency, please list:

Prescribed Medication:		**Dosage:**	
Circumstances under which the medication should be administered:			
Any indicators that the medication should not be administered:			

What is the expected result of administering the medication:
What are the possible side effects of this medication, including ability to safely participate in all areas of the program (such as Technical Programs, Food School, Physical Education)?
What, if any, are the effects of a delay in the administration of the medication or a missed dosage?
Any additional instructions?
Instructions for storage/refrigeration:

☐ A Plan of Care has been co-created with the school.

C. If medication is to be administered routinely, please list:

Prescribed Medication				
Dosage				
Time of Administration				
Possible side effects, including effects of a delayed or missed dosage				
Additional instructions (e.g., storage)				

In submitting this request that school personnel administer the above noted prescription medication to my/our child, I/we acknowledge and agree that:

(a) School personnel will be administering the prescription medication in the place of a parent/guardian.

(b) School personnel staff are not health care professionals and have not received any medical training, which may constitute an additional risk to the student, for which I/we accept complete responsibility.

(c) I/we are solely responsible for providing the prescribed medications to the school, in an adequate supply for up to two weeks. Some medications cannot be stored at school (please consult the school administration regarding the appropriate student health procedure).

(d) I/we have considered the possible side effects of the medication and confirm that our child will be able to safely participate in all aspects of his/her program (such as Technical Programs, Food School, Physical Education).

(e) I/we will supply the prescribed medication in the original container(s) from the pharmacist, and will ensure that the container clearly displays:

  (i) the name of the student,

  (ii) the name of the medication,

  (iii) the dosage,

  (iv) the name of prescribing regulated health care provider,

  (v) frequency of administration, and

  (vi) date of expiry.

(f) School personnel may in some circumstances be unable to administer the medication described above as required, in which case I/we will be contacted in a timely manner at the phone number(s) provided on this Form.

(g) I/we will immediately notify the Health Centre of any change to my child's medication(s), and will forthwith complete a revised Form 1.

(h) I/we acknowledge and agree that the personal information provided on this Form and otherwise in support of our child will be disclosed as necessary to school staff and volunteers, as well as board and Transportation Consortium personnel.

☐ Yes, a copy of the pharmacist's instruction for the administration of the prescribed medication is attached.

I acknowledge that I am aware and understand my child's medical condition and the risks associated with its care and emergency treatment, and that Appleby College and its staff and volunteers are acting in their role as educators and not health professionals.

_____ _____

Parent/Guardian Signature Date

D. To be completed by the Health Care Professional:

The information in this form has been reviewed by a Regulated Health Professional.

_____

Name (Please print)

_____ _____

Signature Date