

FORM 2: AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION BY STUDENT

Form 2 is to be completed by a parent/guardian in order to request authorization for a student to self-administer a prescription medication while at school or at a school sponsored event.

Form 2 must be reviewed annually and, if there are no changes to the medication, an updated parent/guardian signature (Appendix C) is required. A new Form 2 must be submitted whenever there is any change to the student's medication(s).

This request will only be considered if:

- (a) The medication is prescribed by a regulated health care provider;
- (b) The administration of a prescribed medication on either a routine or emergency basis is necessary for the student to attend school or a school sponsored event; and
- (c) It is appropriate for the student to self-administer the prescribed medication.

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? | | | |
| 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, I/we acknowledge and agree that:

- (a) If student's medication is to be stored at school, I/we are solely responsible for providing the prescribed medication in an adequate supply for up to two weeks. Some medications can not be stored at school. (Please consult the school administration regarding the appropriate student health procedure).
- (b) Any medication will be provided in the original container(s) from the pharmacist, which will clearly display:
 - (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.
- (c) Because I/we are giving our permission for the student to self-administer the medication, I/we acknowledge and agree that school staff will not be designated or trained to administer the medication.
- (d) I/we will immediately notify the Principal of any change to the student's medication(s), and will forthwith complete a revised Form 2.
- (e) 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.

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 the Halton District School Board and its staff and volunteers are acting in their role as educators and not health professionals.

Parent/Guardian Signature

Date

Personal information is collected on this form in compliance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M56, and is collected under the authority of the Education Act, R.S.O. 1990, c. E.2.

Personal information will be used for purposes related to the regular operational requirements of the educational and administrative functions of the Halton District School Board.

For additional information about how the HDSB uses personal information please see the HDSB Statement of Personal Information Practices or, contact your school Principal.