Halton District School Board

2016-17 PARENT/PHYSICIAN REQUEST FOR SCHOOL PERSONNEL TO **ADMINISTER PRESCRIBED ROUTINE MEDICATION**

TO BE COMPLETED BY PARENT/GUARDIAN
and returned immediately to the school office before the commencement of the Administration of the Prescribed Routine Medication.

Name of Student	**Date of Birth (year/month/day)**	**Grade**
Name of Parent/Guardian	**Address**	
Home Telephone	**Business Telephone**	**Cell phone**
Emergency Contact #1 Name	**Work Telephone**	**Cell phone**
Emergency Contact #2 Name	**Work Telephone**	**Cell phone**
Name of Physician	**Telephone**	

For School Use Only:

Date Received	
Action Taken	
Personnel Administering Prescribed Routine Medication	

Principal's Signature:

(See over)

Halton District School Board

Why is this medication required?

_____

Special Instructions (storage, training required for staff involved):

_____

_____

Medication Prescribed	**Dose**	**Time of Administration** AM Noon PM
1.		
2.		
3.		

Duration of Continuing Medication(s): _____

What are the specific side effects to your child? _____

_____

With an increasing number of children on daily medications, it is essential that the above information be known.

I/We understand that the decision to permit an employee of the Halton District School Board to administer medication to my son/daughter is a personal, family decision.

I/we acknowledge that the administration of medication by employees and agents of the Board who are not health professionals is being undertaken in the best interests of the students as a service and as such constitutes a risk to the student of possible loss, damage or injury. I/we acknowledge that employees or agents of the Halton District School Board may in some circumstances be unable to administer the medication described above as required or in a timely manner and may be required to refuse to administer any or all medications requested by me/us to be administered.

I/We acknowledge that neither the Halton District School Board nor its employees will accept responsibility for any loss, damage or injury to my child or his/her property arising out of the administration or failure to administer the medication described above, and I/we agree to release any staff member and the Halton District School Board from any legal liability that may result from the administration of or failure to administer medication.

I will complete a revised form if there are any changes or modifications to the administration of my child's prescribed routine medication.

_____

Date: **Signature of Parent/Guardian**

The personal and/or health related information gathered on this form is being collected, retained, used and disclosed in accordance with the Municipal Freedom of Information and Protection of Privacy Act, Education Act and Personal Health Information Protection Act.

Note: This request will terminate on July 31 of each school year.