

The Student Health Plan is supported by Administrative Procedure 316: Administering Student Medication. This form must be:

- completed if a physical or medical condition may affect the student's attendance at school;
- completed if medication is to be taken at school; and
- reviewed and updated annually or sooner if there is a change in the student's health concern or school registration.

<b>Student Name:</b> <i>(Last name, First Name)</i>		<b>School Year:</b> <i>(yyyy-yyyy)</i>
<b>Birth Date:</b> <i>(dd-mm-yyyy)</i>	<b>School:</b>	<b>Grade:</b>

## Section 1 - Health Concern or Medical Condition

Describe the health concern or medical condition:

## Section 2 – Medication Management

### a) Medical Information

*Identify name, dosage, frequency, timing of administration, storage requirements and termination date*

### b) Potential side effects of medication

*List symptoms or symptoms that may indicate the condition is not under control or that medication needs to be adjusted. Identify specific steps the student or teacher should take to monitor this condition.*

**Section 2 – Medication Management (continued)**

**c) Response to side effects**

**d) Responsibilities – outline who does what and when**

**Section 3 – Communication**

**How and when will parents/guardians be contacted, and under what conditions?**

**Section 4 – Parent (s) / Legal Guardian Contact Information**

Name	Address with Postal Code	Phone(s)	Email

## Section 5 - Signatures

### Acknowledgement and Waiver by Parent or Independent student

1. I hereby request and give my permission to the above school to administer medication (including Epi-Pen and transportation to hospital for life-threatening allergies) prescribed on this form to my child.
2. I acknowledge the following:
  - a. Parents/guardians are responsible for supplying the medication in its original container identifying the owner and contents. The supply will be replenished when necessary without contact by the school.
  - b. The student and the student's parents are primary responsibility for medication administration.
  - c. If granted, approval of this request is valid only for the school and school year in which it is submitted.
  - d. Any change in the student's medical condition or medication must be brought to the principal's attention promptly.
  - e. Staff actions will be limited to what is possible in a school setting and what can be done by persons untrained in medical procedures.
  - f. Administration of medication through an epinephrine auto-injector will be provided in emergencies related to anaphylactic shock.
  - g. Parents are responsible for keeping contact information, including emergency contacts, current and up to date.

We, the parents/guardians, hereby waive all rights of action on behalf of ourselves and/or our child in case of any cause of action that may arise as a result of the principal/designate proceeding with our request.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Healthcare provider signature

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Principal approval signature

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Authorization for Collection of Personal Information

Personal information is collected under the authority of the Education Act and the Freedom of Information and Protection of Privacy Act. This information will be used to respond to the identified medical or physical needs of the student named above. If you have any questions regarding the collection of this information, contact the school principal.

**School Use**

Person administering medication/personal care: \_\_\_\_\_

Alternate person: \_\_\_\_\_

Location where medication/personal care supplies are kept: \_\_\_\_\_