REQUEST FOR ADMINISTRATION OF MEDICATION/MEDICAL TREATMENT

(Retain copy of Page 1 to 3 in Emergency File to accompany student on all field trips)

The personal information on this form is collected pursuant to the Education Act and section 33 of the Freedom of Information and Protection of Privacy Act. The purpose of this collection is to respond to the student's medical needs including the administration of medication and or responding to potential emergency situations. If you have any questions concerning the collection, use or disclosure of this information please contact the FOIP Coordinator at 780-842-3992.

Please Print
Student's Name:_____ Date of Birth:_____

School:_____ Grade:_____

Teacher:_____ Principal:_____

Parent/Guardian Name:_____

Address:_____

Phone: Home_____ Day(Mother)_____ Day(Father)_____

Other Emergency Family Contact: Name_____

Phone:_____ Relationship:_____

Personal Health Care Number (optional):_____

MEDICAL INFORMATION

1. Medical intervention which is being requested of school staff (please check)
   ☐Medical Administration
   ☐Life Threatening allergic reaction to:_____
   ☐Medical Procedure:_____

2. Purpose of Intervention:_____

3. Why is this necessary at school?_____

   _____

4. Medical Profile (Please include all medications your child takes – attach if necessary)

Name of Medication	Dosage to be given	Frequency (Specify Time of Day)	Duration (daily) From/To	Anticipated Reactions

5. Student is able to self-administer: ☐Yes ☐No

6. Special Storage Information: _____

7. Emergency procedure in event of reaction: _____

8. Designate medical facility/hospital in the event of an emergency: _____

_____ _____
Physician's Name Physician's Telephone

I am providing this information to assist in responding appropriately to the medical needs of my child during school hours. This information will be shared with school and bus transportation staff on a need-to-know basis.

_____ _____
Parent(s)/Guardian Signature(s) Date

_____ _____
Student Signature Date

East Central Catholic Schools

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION/MEDICAL TREATMENT

This Authorization is Subject to the Following:

- The parent/legal guardian is to provide the medication or medical supplies as prescribed or determined by the student's physician and specific details pertaining to the administration of the medical treatment.
- The medication and certain supplies are to be provided by the parent(s)/legal guardian(s) in the original container.
- For medical equipment, complete and clear instructions as to its proper use are to be provided by the parent(s)/legal guardian(s). The good working order of these devices will be the responsibility of the parent/legal guardian.
- The parent/legal guardian is to provide instruction on the proper administration of medication intervention as per Administrative Procedure 312 – Administering Medical Treatment to Students.
- The parent is to provide instruction on the proper administration of the medical treatment **in cooperation with and under the direct supervision of a medical practitioner/health professional familiar with the procedure (as necessary). ****
- The parent/legal guardian is to repeat and update this instruction should:
  - The student's medical condition change;
  - The intervention requirements change;
  - There be a change in school staff assisting the student in the medical intervention; and
  - Assisting staff request a review or refresher of the medical intervention.
- The parent/legal guardian understands that for specific medical situations, school policy will require assisting staff to summon medical practitioners or paramedics.

I have provided the above and completed the required instruction at

_____ on _____

(location) (date)

This session was attended by the following staff:

1._____ 2._____

3._____ 4._____

5._____ 6._____

_____ _____

Parent/Guardian Signature Date (Y/M/D)

East Central Catholic Schools

CONFIRMATION FROM STUDENT'S PHYSICIAN OR PHARMACIST

I hereby confirm that the following medication _____

Must be administered to _____ during school hours.
(Name of Student)

I also confirm that:

a) The service required is of such a simplistic nature that a lay person (teacher, educational assistant, administrative assistant) could successfully perform the function;
b) The service has to be performed during regular school hours and/or approved school activities;
c) The service is critical to the well-being and functioning of the student; and
d) No other reasonable alternative is available (i.e. through a community agency).

Name of Physician or Pharmacist:_____ Date:_____

Signature of Physician or Pharmacist:_____

This information has been reviewed by the school administration.

_____ _____
Signature Date