Form 316-1

Notification of Medical Condition & Personal Care Request/Authorization

Name of Student:_____ Birthdate: _____

Address: _____ Home Phone: _____

Father/Guardian Work Phone: _____

Mother/Guardian Work Phone:_____

Name of Medication: _____

Dosage/Personal care required. (Where procedures beyond a written prescription are required, written instructions from the doctor shall be attached.)_____

_____

_____

Purpose of medication/personal care (e.g. asthma, diabetes, etc.)_____

_____

Name of Doctor: _____ Doctor Phone: _____

Medication/personal care is to be given as follows: Location: _____

_____

Time: _____

Administered by:_____

Alternate:_____

It is the student's responsibility to come to receive medication. Yes ☐ No ☐

Alternate Arrangements: _____

This medication is to be:

- ☐ self-administered by student (staff member informed)
- ☐ self-administered by student under supervision of staff member
- ☐ administered to student by staff member
- ☐ used only when the following symptoms appear: _____

_____

Possible side effects (Please attach pharmacist's printout, if available): _____

Possible effects if the medication is not administered according to the prescribed schedule._____

_____

Termination date of medication/personal care:_____

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Disposal procedures for unused medication (confirm with parent before enacting).

Emergency procedures to be implemented Yes ☐ No ☐ See next page ☐

Detail of Emergency Procedures are attached to this form Yes ☐ No ☐

Physician's Name: _____ Signature: _____ Date: _____

Parent/Guardian Signature _____ Date: _____

Freedom of Information and Protection of Privacy – Disclosure Sec. 32

The personal information requested on this authorization form is being collected to determine the specific medication and personal care for your child that is being requested of the school. The information will be made available on a need to know basis to people who are working with your child and providing the required care. The information is collected pursuant to the *School Act* and Regulations thereto. It will not be disclosed to any other person or organization except as authorized by the *Freedom of Information and Protection of Privacy Act.* If you have questions about the collection and use please contact the principal of the school your child attends.

Note: This section must be completed if medication is to be administered to the student at school.

I hereby request and give my permission for the below-named school to administer medication prescribed on the reverse of this form to my child. I make this request in the knowledge that school personnel have no special training or limited training in the administration of the medication. Parents/guardians must inform the principal of any changes in the administration of the medication. A new request/authorization form must be completed and given to the principal.

In addition, I accept responsibility to ensure the safe transportation of these medications to the school. I hereby acknowledge that at my request the principal or her/his designate has been authorized to administer the prescribed medication.

Namely: _____

To my son/daughter/ward: _____

Date of Birth: _____ Class: _____

School: _____

And I hereby release the principal and/or his designate and Foothills School Division No.38 from any claim for harmful effects resulting from the administration of the prescribed medication and I hereby agree to indemnify and save harmless the principal and/or designates and Foothills School Division No. 38 from all claims that may result therefrom. I have received a copy of the Board's policy on the administration of medication, and agree to follow the policy.

_____

Signature of Parent/Guardian