



Halton District School Board

EXTENDED DAY PROGRAM PARENT/PHYSICIAN REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER PRESCRIBED ROUTINE MEDICATION

This form is to be completed by the Parent/Guardian and returned immediately to the Extended Day Program Staff before the commencement of the administration of the prescribed routine medication.

Name of Student: _____ Ontario Health Card No. _____

Name of Elementary School: _____

Name of Physician: _____ Telephone: () _____

Medication Prescribed: _____ Dosage: _____

Time of Administration: (AM, Noon, PM) _____

Why is this medication required? _____

Duration of Continuing Medication(s): _____

What are the specific side effects to your child? _____

Special Instructions (storage of inhaler/puffer, training required for staff involved): _____

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.

Signature of Parent/Guardian: _____ Date: _____

Note: This request will terminate on June 30th of each school year.

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.

For Extended Day Program Staff Only

Date Received: _____

Action Taken: _____

Personnel Administering Prescribed Routine Medication: _____

Staff Signature: _____ Date: _____