Halton District School Board

ANNUAL REVIEW OF MEDICAL INFORMATION - NO CHANGES

A. To be Completed by Parent/Guardian (please print):

Name of Student: _____

Student's Date of Birth: _____

Name of Parent / Guardian: _____

Please check the applicable boxes:

Administration of Prescribed Medication:

☐ There are no changes to my child's prescription and administration of medication for the _____ school year .

☐ There are changes to my child's prescription and/or administration of medication. I will complete an updated Form 1 or 2.

☐ Not applicable

Plan of Care (i.e., Anaphylaxis, Diabetes, Epilepsy, Asthma):

☐ There are no changes to the requirements set out in my child's Plan of Care. Please update staff names as appropriate for the _____ school year.

☐ There are changes to my child's Plan of Care. I will provide updated information to the school.

☐ Not applicable.

I acknowledge that I am aware and understand my child's medical condition and the risks associated with its care and emergency treatment, and that the Halton District School Board and its staff and volunteers are acting in their role as educators and not health professionals.

_____ _____

Parent / Guardian Signature Date

Personal information is collected under the authority of the Education Act, R.S.O. 1990, c. E.2 in compliance with the Personal Health Information Protection Act, S.O. 2004, c. 3 and the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M56. Personal information is collected for purposes of providing professional services, consultation and advice in the context of the Halton District School Board's educational mandate. Questions about this collection may be directed to the Superintendent of Health.