Appendix A to 6061 Procedures

2135 Sills Street
Thunder Bay, Ontario P7E 5T2
Telephone (807) 625-5100

| ADMINISTRATION OF *PRESCRIBED* MEDICATION | | | MED FORM 1 |
|---|---|---|---|
| **PARENT/GUARDIAN REQUEST/RELEASE** | | | |
| STUDENT: | | D.O.B.: | |
| ADDRESS: | | HOME PHONE: | |
| PARENT/GUARDIAN: | | WORK PHONE: | |
| EMERGENCY CONTACT: | | PHONE: | |
| SCHOOL: | GRADE: | PRINCIPAL: | |
| PRESCRIBING PHYSICIAN: | | | |
| ADDRESS: | | PHONE: | |

I/We, the parents/guardians of the above-named student, hereby request and give permission to Lakehead District School Board to provide for the administration of prescribed medication to our child during school hours, according to 6061 Administration of Oral Medication Policy and Procedures adopted by the Board which we have read, understood and acknowledge receiving a copy.

I/We release Lakehead District School Board, its employees and agents, from any liability for loss, damage or injury, howsoever caused, to our child's person or property arising out of the administration of prescribed medication under the 6061 Administration of Oral Medication Policy and Procedures.

I/We give permission to Lakehead District School Board to release medical information on the above-named student in case of a medical emergency.

______________________________ ______________________________
Parent/Guardian (signature) Date

______________________________
Witness (signature) Date

Please retain the original of this form in the student's OSR.

Lakehead Public Schools

Appendix A to 6061 Procedures

2135 Sills Street
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| **ADMINISTRATION OF MEDICATION** | **MED FORM 2** |
| --- | --- |
| **PHYSICIAN INFORMATION** | |
| STUDENT: | D.O.B.: |
| ADDRESS: | HOME PHONE: |
| PARENT/GUARDIAN: | WORK PHONE: |
| SCHOOL: | GRADE: |
| PRESCRIBING PHYSICIAN: | PHONE: |
| ADDRESS: | |
| MEDICAL CONDITION REQUIRING MEDICATION: | |
| MEDICATION PRESCRIBED:<br>DOSAGE:____________________<br>FREQUENCY OR TIME SPECIFIED FOR ADMINISTRATION:____________________<br>METHOD OF ADMINISTRATION:____________________<br>POSSIBLE SIDE EFFECTS OR REACTION:____________________<br>SUGGESTED RESPONSE TO SIDE EFFECTS:____________________<br>DURATION OF MEDICATION TO BE GIVEN:____________________ | |
| ____________________<br>Prescribing Physician (signature) | ____________________<br>Date |

Please retain the original of this form in the student's OSR.

***N.B.:** Any fees charged for the completion of this form are the responsibility of the student's parent(s)/guardian(s).*

Lakehead Public Schools

Appendix A to Procedures 6061

2135 Sills Street
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| ADMINISTRATION OF MEDICATION | MED FORM 3 |
|---|---|
| **CONSULTATION FOR SERVICE** | |
| STUDENT: | D.O.B.: |
| ADDRESS: | HOME PHONE: |
| SCHOOL: | GRADE: |

I/We, the parents/guardians of the above-named student, hereby give permission to:

- Lakehead District School Board to release information on Med Forms 1 and 2 to the specified health professional.
- the health professional to consult regarding the administration of prescribed medication to our child.

Name of Health Professional

Parent/Guardian (signature) ____________________ Date ____________________

Witness (signature) ____________________ Date

**CONFIRMATION OF TRAINING**

An assessment has been conducted and staff has been trained in the administration of the prescribed medication to the above-named student.

Health Professional (signature) ____________________ Date

Staff member(s) (signature) ____________________ Date

FREEDOM OF INFORMATION
Personal information for assessment is collected under the authority of the Education Act, R.S.O., 1990, c. E 2, R.S.O. 1990, c. M. 56, and will be used in the administration of prescribed medication to a student. Questions regarding the collection of this information should be directed to the school Principal.

Please retain the original of this form in the student's OSR.

Lakehead Public Schools

Appendix A to Procedures 6061

2135 Sills Street
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## ADMINISTRATION OF MEDICATION — MED FORM 4

### RECORD OF ADMINISTRATION

| | | |
|---|---|---|
| STUDENT: | D.O.B.: | (picture) |
| SCHOOL/GRADE: | TEACHER: | |
| PARENT/GUARDIAN: | HOME PHONE:<br>WORK PHONE: | |
| PRESCRIBING PHYSICIAN: | PHONE: | |

| Date | Name of Medication | Colour/ Manufacturer | Amount/ Dosage | Time Given | Staff Signature | Comments/Observations/ Reactions |
|---|---|---|---|---|---|---|
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| ADMINISTRATION OF MEDICATION | | | | | | MED FORM 4 |
|---|---|---|---|---|---|---|
| RECORD OF ADMINISTRATION | | | | | | |
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Appendix A to Procedures 6061
2135 Sills Street
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| **ADMINISTRATION OF MEDICATION** | | **MED FORM 5** |
|---|---|---|
| ***MANAGEMENT of*** **EMERGENCY** ***MEDICAL CONCERNS*** | | (picture) |
| STUDENT: | D.O.B.: | |
| ADDRESS: | PHONE: | |
| SCHOOL/GRADE: | TEACHER: | |
| PARENT/GUARDIAN: | WORK PHONE: | |
| EMERGENCY CONTACT: | PHONE: | |
| PRESCRIBING PHYSICIAN: | PHONE: | |
| ADDRESS: | | |

**SPECIFIC MEDICAL EMERGENCY:** (give a detailed description of the condition and possible symptoms) ____________________

____________________

**MEDICATION PRESCRIBED:** ____________________

____________________

Location of Medication: ____________________

Method of Administration: ____________________

Possible Side Effects/Reaction: ____________________

**ACTION-EMERGENCY PLAN:** ____________________

____________________

____________________

____________________

Appendix A to Procedures 6061
2135 Sills Street
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| ADMINISTRATION OF MEDICATION | | MED FORM 6 |
|---|---|---|
| **RETURN OF MEDICATION FORM** | | |
| STUDENT: | D.O.B.: | |
| PARENT/GUARDIAN: | | |
| SCHOOL: | GRADE: | PRINCIPAL: |
| I/We, the parents/guardians of the above-named student, acknowledge that the following medication has been returned to us:<br><br>MEDICATION:<br><br>QUANTITY: | | |
| Parent/Guardian<br>*(signature)* | Name<br>*(please print)* | Date |
| Witness<br>*(signature)* | Name<br>*(please print)* | Date |

Lakehead Public Schools

Appendix A to Procedures 6061
2135 Sills Street
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| ADMINISTRATION OF MEDICATION | | MED FORM 7 |
|---|---|---|
| **PARENTAL/GUARDIAN REQUEST TO TERMINATE ADMINISTRATION OF MEDICATION** | | |
| STUDENT: | | D.O.B.: |
| PARENT/GUARDIAN: | | |
| SCHOOL: | GRADE: | PRINCIPAL: |

I/We, the parents/guardians of the above-named student, hereby request and give permission to Lakehead District School Board to terminate the administration of prescribed medication to our child during school hours, according to 6061 Administration of Oral Medication Policy and Procedures adopted by the Board which we have read, understood and acknowledge receiving a copy.

I/We release Lakehead District School Board, its employees and agents, from any liability for loss, damage or injury, howsoever caused, to our child's person or property arising out of the termination of the administration of prescribed medication under the Board's 6061 Administration of Oral Medication Policy and Procedures.

| Parent/Guardian *(signature)* | Name *(please print)* | Date |
|---|---|---|
| Witness *(signature)* | Name *(please print)* | Date |