Lakehead Public Schools

2135 Sills Street
Thunder Bay, Ontario P7E 5T2
Telephone (807) 625-5100
Fax (807) 623-5833

ADMINISTRATION OF 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 Policy and Procedures 6060 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 Board's Administration of Medication Policy.

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.

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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: DOSAGE: _____ FREQUENCY OR TIME SPECIFIED FOR ADMINISTRATION: _____ METHOD OF ADMINISTRATION: _____ POSSIBLE SIDE EFFECTS OR REACTION: _____ SUGGESTED RESPONSE TO SIDE EFFECTS: _____ DURATION OF MEDICATION TO BE GIVEN: _____	
_____ Prescribing Physician (signature)	_____ 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).*

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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 have 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.

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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: WORK PHONE:	
PRESCRIBING PHYSICIAN:	PHONE:	

Date	Name of Medication	Colour/ Manufacturer	Amount/ Dosage	Time Given	Staff Signature	Comments/Observations/ Reactions

ADMINISTRATION OF MEDICATION						MED FORM 4
RECORD OF ADMINISTRATION						
Date	Name of Medication	Colour/ Manufacturer	Amount/ Dosage	Time Given	Staff Signature	Comments/Observations/ Reactions

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ADMINISTRATION OF MEDICATION		MED FORM 5
EMERGENCY SERVICES		
STUDENT:	D.O.B:	(picture)
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: _____

_____

_____

_____

(Supersedes September 3, 1996)

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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:

MEDICATION:

QUANTITY:

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

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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 Policy and Procedures 6060 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 Administration of Medication Policy.

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