



AD	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.

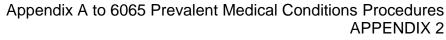
Parent/Guardian (signature)

Date

Witness (signature)

Date

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





ADMINISTRATIO	ON OF MEDICATION	MED FORM 2				
PHYSICIAN	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:						
Dressrihing Dhusisian (signature)	D_+(					
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).



## 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)

Witness (signature)

## **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)

Staff member(s) (signature)

<u>FREEDOM OF INFORMATION</u> 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.

Date

Date

Date

Date



Appendix A to 6065 Prevalent Medical Conditions Procedures APPENDIX 4

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

ADMINISTRATION OF MEDICATION					MED FORM 4	
RECORD OF ADMINISTRATION						
STUDENT	:	D.0	.B:			-
SCHOOL/	GRADE:	TEACHER:			(picture)	
PARENT/0	GUARDIAN:	HOME PHONE: WORK PHONE:				
PRESCRI	BING PHYSICIAN:	PHC	DNE:			
Date	Name of Medication	Colour/ Manufacturer	Amount/ Dosage	Time Given	Staff Signature	Comments/Observations/ Reactions

Appendix A to 6065 Prevalent Medical Conditions Procedures APPENDIX 4

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



ADMINISTI	RATION OF MEDICA	ATION	MED FORM 5
EMERGENCY SERVICES			
STUDENT:	D.O.B:		
Address:	PHONE:		(picture)
SCHOOL/GRADE:	TEACHER:		
PARENT/GUARDIAN:		WORK PHONE:	
EMERGENCY CONTACT:		PHONE:	
PRESCRIBING PHYSICIAN:		PHONE:	
ADDRESS:			
SPECIFIC MEDICAL EMERG	ENCY: (give a detailed desc	ription of the condition and possible	symptoms)
MEDICATION PRESCRIBED:			
MEDICATION I RECORDED.			
Location of Medication:			
Method of Administration:			
Possible Side Effects/Reaction	:		
ACTION-EMERGENCY PLAN	:		



	MED FORM 6				
RETURN OF MEDICATION FORM					
STUDENT:		D.O.B:			
PARENT/GUARDIAN:					
SCHOOL:	GRADE:	PRINCIPAL:			
I/We, the parents/guardians of the a been returned to us:	above-named student, a	acknowledge that the	e following medication has		
MEDICATION:					
QUANTITY:					
Parent/Guardian (signature)	Name please p		Date		
Witness (signature)	Name		Date		
(signature)	(please p	""""			

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A	DMINISTRATION OF MEDICAT	ION 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			