APPENDIX A

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AND STORAGE OF MEDICATION

This form notifies school personnel that a student is authorized to self-administer medication during school hours. The Medical Information Form must also be completed. Medication found in a student's possession may be confiscated if the school has not received these completed forms.

If it is necessary for more than one day's dosage to be stored at school or assistance is otherwise required for the storage of the medication, please indicate below that storage of the medication is requested.

The Principal may, in his or her discretion, require that medication be stored by the school.

When medication is to be stored by the school, the Principal will arrange procedures for storing and accessing the medication.

Regardless of whether medication is stored by the school or kept by the student, no records will be kept by school personnel of the student's self-administration of medication.

Copies of this form, the Medical Information Form and any Protocol attached hereto shall be provided to: parent(s)/guardian(s) and/or, where appropriate, the student, the Principal and Board personnel to be designated by the Principal as required.

A. Student Information

Student's Name____ Date of Birth______________________________

Parent's Name ____

School__________________________________Grade/Course_______________Teacher(s)______________________

Home Telephone Number(s) ____________________Parent(s) Work Telephone Number(s) ______________________

Address____

Emergency Contacts & Telephone Numbers ____

Physician ____ Telephone Number(s)___________________________

B. Storage of Medication

NOTE: A maximum of 1 day's dosage (where applicable) shall be sent each day the medication is required unless assistance with storage of the medication has been arranged with the Principal.

Please check one:

- ☐ Assistance with storage of the medication is requested.
- ☐ Assistance with storage of the medication is not requested.
- ☐ Storage Requirements.

C. Medical Information Form (Non-Emergency)

This section must be completed by the student's physician if requested by the Principal.

Name of medication____

Medical condition requiring this medication____
____

Description of medical condition____
____

Form of the medication (e.g. tablets, liquid)____
____

Time(s) to be taken during school hours ____
____

Dosage____

Instructions for ingestion (e.g. with food, water)____
____

Date of final administration .____

Possible side effects ____

Necessary action in event of side effect____

Storage requirements: ____

Any other special instructions or other information which will assist school personnel

____
____
____

Physician Signature (where required)______________________________Date__________________________

D. Authorization of Parent(s)/Guardian(s)/Adult Student

I/We am/are **[the parent(s)/guardian(s) of]** ____, **a student at** ____ **School**. I/We hereby advise that the medication specified in the Medical Information Form shall be self-administered by this student/me in accordance with this form, the Medical Information Form. We understand and acknowledge that it is my/our responsibility to supply the medication, labelled as required by the Principal, and to provide information sufficient for a full understanding of any procedures to be followed by school personnel. I/we understand that school personnel storing medication will not keep a record of its self-administration.

I/We hereby acknowledge that this authorization will terminate automatically on June 30 of this school year, or earlier as specified in the Medical Information Form. I/We acknowledge that a new Authorization Form for the Self-Administration of Medication & Storage of Medication and a new Medical Information Form must be immediately completed if there is any change in the information contained therein.

I/We hereby acknowledge that the Near North District School Board (the "Board"), its agents or employees shall not be responsible for the administration of such medication, and I/we hereby release the Board, its agents and employees from all manner of actions, causes of action, suits, losses, damages or injuries, however caused, arising out of the self-administration of medication by this student/me, or failure of this student/me to self-administer such medication or to self-administer such medication properly, or arising from storage of medication by Board employees, and I/we do also hereby indemnify the said Board, its employees or agents for any losses or damages sustained by the Board as a result of such actions or proceedings being commenced against them by myself/ourselves, or any of this student's/my relatives, agents, sponsors or guardians.

I/We hereby acknowledge that I/we have read and fully understand the terms set out herein.

____ ____
Parent/Guardian or Adult Student Signature Date

____ ____
Parent/Guardian or Adult Student Signature Date

NOTE:

1. The information gathered in this form is collected pursuant to the Education Act, the Municipal Freedom of Information and Protection of Privacy Act, related legislation and policies and the policies of the Near North District School Board. This information will be used to assist with meeting the health needs of the student. This form will be kept in the student's pupil records. If there are any questions about the information gathered on this form, please contact the Principal.
2. After June 30 of each year, a new form must be completed for the following year.