OCDSB 988 HANDLING OF PRESCRIBED MEDICATION FOR STUDENTS WITH NON-LIFE THREATENING MEDICAL CONDITIONS

(Reference Procedure PR.691.SCO Administration of Prescribed Medication for Students with Non-Life Threatening Medical Conditions)

This form applies only when parents/guardians/caregivers request the involvement of school with handling prescribed medication for students with non-life threatening conditions.

Student Information

- Student Name (first, middle, last): ______________________________________
- Student Date of Birth (day/month/year): ______________________
- School Name: ______________________________________
- Grade: _______________________

Parent/Guardian/Caregiver Information (required if student is under 18 years of age)

- First and Last Name : _____________________________________
- Home Phone Number: _______________________
- Email Address: ______________________

Emergency Contacts (Please list in order of priority)

Name	Relationship	Daytime Phone	Alternate Phone	Email
1.				
2.				
3.				

Prescribing Healthcare Provider Information

- Name: ____
- Telephone Number: _____________________________________
- Profession/Role:

Physician

Nurse Practitioner

Registered Nurse

Pharmacist

Respiratory Therapist

Certified Respiratory Educator

Certified Asthma Educator

Other. Please specify: ______________________________

I/We authorize:

The health care provider(s) listed herein to share health information about the student with school staff as required to ensure the accuracy of the information contained in this form and to provide information as required to ensure the safety and well-being of the student.

The OCDSB staff to contact the health care provider(s) listed herein as required to attend to the well-being of the student.

Medication Information

- Name of Medication: ____
- Date of Prescription: ____
- Dosage of Medication: ____
- Time of Administration: ____
- Special instructions for Administration:____________________________________

____

- Duration of Medication Regime: ____
- Caution of Notable Side Effects: ____

____

This medication may be administered during school hours or school-related activities only when REQUIRED by the healthcare professional(s) listed herein.

Please include all special instructions, prescription labels, or notes pertaining to each medication.

I/We acknowledge that it is my/our responsibility to submit enough medication and medical supplies to school and to track the expiration date.

Is the medication prescribed on an "as needed" basis?

Yes

Please complete the following:

- The clear, specific and observable symptoms/behaviours that requires the administration of medication: ____
- The level of intensity: ____
- The length of time the symptoms/behaviours are observed prior to the administration of medication: ____
- How many times in a 24 hour period the PRN can be administered: _____________

PLEASE NOTE THAT staff will obtain verbal consent from the parent/guardian or a designate with signing authority prior to each administration as staff are not in a position to conduct medical assessment. Where consent cannot be obtained, the principal/designate will NOT administer the medication.

No.

Parent(s)/Guardian(s)/Caregiver(s) Authorizations to Handle Prescribed Medication

I/We authorize:

The OCDSB staff to administer the medication to the student as prescribed. I/We understand that the administration of medication involves certain elements of risk, including, but not limited to illness, adverse reactions or other complications. I/We understand that OCDSB staff are not medically trained to administer medication and bear sole responsibility for any adverse reaction or associated risks that might occur following the administration of medication.

The OCDSB staff to supervise the student administration of medication. I/We understand that the administration of medication involves certain elements of risk, including, but not limited to illness, adverse reactions or other complications. I/We understand that OCDSB staff are not medically trained to supervise the administration of medication and bear sole responsibility for any adverse reaction or associated risks that might occur following the administration of medication.

The OCDSB staff to store the medication as required below.
Storage Instructions: ____
____

The OCDSB staff to share this form as necessary with individuals in direct contact with the student to attend to their well-being and medical needs at school and during school activities. This may include school and office staff, occasional staff, and before- and after-school program staff.

I confirm that the information herein is accurate and up to date. I understand that I must re-submit this form in case of any changes to the student's medication, condition, level of independence, or treatment plan.

Parent/Guardian/Caregiver/Adult Student Name:

____

Parent/Guardian/Caregiver/Adult Student signature:

____

Date: __________________________________

The personal information of this form is collected under the authority of the Education Act (RSO. 1990 c.E.2) and in accordance with the Municipal Freedom of Information and Protection of Privacy Act (RSO. 1990 c.M56), as amended. It will be used to establish the Ontario Student Record [OSR] and for student and education related purposes such as registration, administration, communication, collection of fees, data reporting, and Student Transportation Services. In addition, the information may be used or disclosed to comply with legislation, for compelling circumstances affecting health and safety or discipline, as required in circumstances related to allow enforcement matters, and with third parties in accordance with established service agreements or in accordance with any other Act. Questions or concerns should be directed to the school principal or the Board's Freedom of Information Coordinator, Ottawa-Carleton District School Board, 133 Greenbank Road, Ottawa, Ontario, K2H 6L3, Telephone 613-596-8211 ext. 8607.