ST. ALBERT PROTESTANT SCHOOLS

REQUEST FOR ASSISTANCE TO ADMINISTER MEDICATION FORM

This form must be completed by the parent/legal guardian/independent student, if the student's attendance at school requires the administration of medication, with or without assistance. Requests for assistance in the administration of medication must be endorsed by the student's physician. The information collected on this form will be used to assess the request and to implement the request where authority is granted. A new form must be completed if the student changes schools, or when the student's condition or medication changes. A new form must be filled for each school year.

STUDENT IDENTIFICATION INFORMATION

Student's Full Legal Name: _____

Birth Date: _____

School Attended: _____

Grade: _____ Teacher: _____

CONTACT INFORMATION

Parent/Legal Guardian Name(s):

Phone Numbers:

(Day) _____ (Name) _____

(Evening) _____ (Name) _____

Specify Additional Emergency Contact: _____

Phone Number:

(Day) _____ (Evening) _____

MEDICAL INFORMATION

Medical condition which necessitates the administration of medication at school: _____

_____

Medication(s) required by student: _____

_____

Please Identify Medication Requirements:

NAME OF MEDICATION	DOSAGE (HOW MANY/MUCH?)	FREQUENCY (HOW OFTEN?)	TIME OF ADMINISTRATION

Please answer each of the following questions for each medication.

How is medication to be stored (specify conditions): _____

Can the student self administer medication: ☐ Yes ☐ No

If the student requires assistance, please specify the nature of assistance: _____

_____

Specify possible side effects requiring emergency action: _____

_____

Emergency procedure in the event of an adverse reaction: _____

_____

Additional instructions or information: _____

_____

Additional instructions or information for student with severe/life threatening allergies: _____

_____

PHYSICIAN'S ENDORSEMENT

The above described medical information provided by the parent/legal guardian or independent student is correct. ☐ Yes ☐ No

The requested assistance is within the competence of a person untrained in medical procedures. ☐ Yes ☐ No

The requested assistance does not require the person assisting to make any judgement concerning the need for the treatment, the efficacy of the treatment, or its outcomes ☐ Yes ☐ No

_____ _____

Physician's Name (*please print*) Physician's Telephone Number

_____

Physician's Location and Address

_____ _____

Signature of Physician Date

AUTHORIZATION REQUEST, CONSENT AND WAIVER

I hereby request that the above identified student be assisted with the administration of medication on the basis as set out above.

If my request is accepted, I acknowledge and agree that:

1. The above medical information is accurate, complete and has been endorsed by the above named physician.
2. Any change in the student's medical condition or medication(s) affecting this administration of medication request will be brought to the attention of the Principal promptly.

3. I will keep current the supply of medication, in its prescribed form, in its original container which identifies the student, and be responsible for the provision of sufficient medication to meet the student's needs.
4. School based staff are not medically trained and will rely upon the information contained on this form in the administration of medication as requested. The school staff will not be exercising any judgement concerning the need for the treatment, the efficacy of the treatment, or its outcomes.
5. If training is required for school based staff to administer the medication, such training is the parent's responsibility, and shall be incurred at no cost to the school.
6. If this request is granted, my consent will remain valid until the next June 30th following the signing of this form, unless otherwise revoked earlier, in writing.

I acknowledge and agree that the information provided herein is accurate and complete and understand why I have been asked to complete this form. I am aware of the risks or benefits of consenting to the administration of medication to my child as indicated above, and understand that a refusal to consent may result in an inability to provide such service to my son/daughter. **In signing this form, the undersigned parent/legal guardian or independent student releases the Board of Trustees of St. Albert Protestant Separate School District No. 6, its elected officials, servants, employees, agents and representatives from and against all claims, suits, demands and actions whatsoever, taken now, or which may be taken in the future, which may arise for or by reason of the administration of medication to the student**. I confirm that I have requested that action be taken by staff as set out above and that such action is authorized by myself. I further agree that staff are authorized to take such emergency action as may be deemed necessary.

Print Name of Parent/Legal Guardian or Independent Student	Signature of Parent/Legal Guardian Independent Student

Date

PRINCIPAL'S APPROVAL

School Name

Name of Principal	Signature of Principal

Date

This personal information is collected under the authority of Alberta's *Freedom of Information and Protection of Privacy Act* ("FOIPP Act") and the *School Act*. This information is necessary in order to assess and respond, as deemed appropriate, to your request for administration of medication to the above described student. The information will be treated in accordance with the privacy protections of the FOIPP Act. If you have any questions about the collection and/or intended use of personal information, please contact the school principal or Michael Brenneis, Associate Superintendent of Finance at (780) 460-3712.