Appendix B
Form A
Administration of Prescribed Medication to Students
To Be Completed By Parent/Guardian

Student Information

Name of Student: _____
Home Address: _____

School: _____
Grade: _____
Classroom/Homeroom Teacher _____

Emergency Contacts

Name: _____

Phone Number(s): _____

Name: _____

Phone Number(s): _____

Name: _____

Phone Number(s): _____

I hereby request, authorize and empower the Halifax Regional School Board to administer medication as described herein to the student named above. I release any staff member and the Halifax Regional School Board from any legal liability that may result from the administration of such medication. I also agree to indemnify the Halifax Regional School Board against claims at any time made by the student name or by MSI arising out of the administration of medication described herein. I also understand that no more than two weeks dosage of the medication(s) is to be in the school at any time and that I am responsible for completing this form in the event that the prescribed medication, amount or frequency of dosage, handling or storage requirements change.

I acknowledge and understand that as a parent or guardian I am responsible to ensure there is medication in sufficient amount and dosage to meet the needs of the student everyday the student is in school and requires the medication to be administered. I also understand and agree that if there is insufficient medication at the school I will be contacted to make arrangements to transport new medication to the school, or to make alternate arrangements for the care of the student for the remainder of the school day. I hereby release any staff member in the Halifax Regional School Board from any legal liability that may result from insufficient amounts of medication being available at the school for administration to the student."

If my child is bussed to school, I also understand that I must provide a current photo of him/her for the purpose of providing all information contained herein to the transportation provider.

_____

Parent/Guardian Name (Please Print) Parent/Guardian Signature

_____

Date

Form A

To Be Completed By Parent/Guardian

Name of Student _____

Name of medical condition(s) requiring medication to be given during school hours: _____

Note: Where possible parent(s)/guardian(s) are asked to establish a schedule for the administration of medication outside of the school day.

	Medication #1	Medication #2	Medication #3
Name of medication			
Brief Desrciption of Medication Ex: Heart Medication			
High Alert	€ Yes € No	€ Yes € No	€ Yes € No
Required intervention	€ Administer by staff € Self administer with staff monitoring	€ Administer by staff € Self administer with staff monitoring	€ Administer by staff € Self administer with staff monitoring
Dose of Medication mg/ml/# tabs/amount			
Frequency			

Time(s) medication to be given during school hours			
Possible side effect(s) of medication			
Course of action in response to side effect(s)			
Route			
Special Handling of Medication			
Extra Comments			
Storage Requirements for medication			
Duration of treatment (start-finish dates)			
Date when medication first prescribed			

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Approved: June 20, 2012
Revised: March 30, 2016

Symptoms of overdose and suggested course of action			
State course of action in the event a dose is missed			
For feeding tube medications only **The amount of water to be flushed through the feeding tube**	**Before med: _____ml** **After med: _____ml**	**Before med: _____ml** **After med: _____ml**	**Before med: _____ml** **After med: _____ml**

_____ _____

Parent/Guardian Signature Date

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