Revised January 2015
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Form 504.1.1 – Medication/Personal Care Request and Authorization

Name of Child: _____ Birthdate:_____

Address: _____ Home Phone:_____

Parent/Guardian Phone:_____

Parent/Guardian Phone (alternate):_____

Name of Medication: _____

Dosage/Personal care required. (Where procedures beyond a written prescription are required, written instructions from the doctor shall be attached.)_____

_____

Purpose of medication/personal care _____

Name of Doctor: _____ Doctor Phone: _____

Medication/personal care is to be given as follows: Location:_____

Time: _____ Administered by: _____ Alternate:_____

It is the student's responsibility to come to receive medication. ☐ Yes ☐ No

Alternate Arrangements:_____

This medication is to be:

- ☐ self-administered by student (staff member informed)
- ☐ self-administered by student under supervision of staff member
- ☐ administered to student by staff member
- ☐ used only when the following symptoms appear: _____

Possible side effects (Please attach pharmacist's printout, if available).

_____

Possible effects if the medication is not administered according to the prescribed schedule: _____

Termination date of medication/personal care:_____

Disposal procedures for unused medication (confirm with parent/guardian before disposal).

_____

Emergency procedures to be implemented: ☐ Yes ☐ No (see next page)

Detail of Emergency Procedures are attached to this form: ☐ Yes ☐ No

Physician's Name:_____Signature:_____Date: _____

Parent/Guardian Signature _____Date: _____

Form 504.1.1 – Medication/Personal Care Request and Authorization cont'd

Access to Information and Protection of Privacy
The personal information requested on this authorization form is being collected to determine the specific medication and personal care for your child that is being requested of the school. The information will be made available on a need-to-know basis to people who are working with your child and providing the required care. The information is collected pursuant to the *Education Act* and Regulations thereto. It will not be disclosed to any other person or organization except as authorized by the *Access to Information Act* and *Protection of Privacy Act.* If you have questions about the collection and use of this information, please contact the principal of the school your child attends or the Director of Inclusive Education, Lethbridge School Division, 403-380-5300.

Note: This section must be completed if medication is to be administered to the student at school.

I hereby request and give my consent for the school named below to administer medication prescribed on the reverse of this form to my child. I make this request in the knowledge that school personnel have no special training or limited training in the administration of the medication. Parents/guardians must inform the principal of any changes in the administration of the medication. In this case, an updated request/authorization form must be completed and given to the principal. In addition, I accept responsibility to ensure the safe transportation of these medications to the school.

I hereby acknowledge that at my request the principal or designate has been authorized to administer the prescribed medication (name of medication):_____

to my child:_____ date of birth: _____

Class:_____ School:_____

And I hereby release the principal or designate and Lethbridge School Division from any claim for harmful effects resulting from the administration of the prescribed medication and I hereby agree to indemnify and save harmless the principal and/or designates and Lethbridge School Division from all claims that may result therefrom. I have received a copy of the Board's policy on the administration of medication and agree to follow the policy.

Signature of Parent/Guardian

_____

SCHOOL USE
Location where medication/personal care supplies are kept:_____
Time of day for administration: _____
Student Responsible for remembering to come for medication: ☐ Yes ☐ No
Alternate Arrangements _____
Person administering medication/personal care:_____
Alternate Person(s): _____
Date and method of returning medication to parent _____