STUDENT MEDICATION FORM

Student's Name: _____ Birthdate: _____

Parent/Guardian: _____ Work Phone: _____ Home Phone: _____

Parent/Guardian: _____ Work Phone: _____ Home Phone: _____

Doctor's Name: _____ Phone #: _____

Describe the medical condition which requires medication to be given within school hours:

_____

_____

Complete this section by attaching current pharmacy medical label(s)
(extra copy can be requested from the pharmacist).

_____

Additional Comments: (possible reactions, consequences of missed dose, time period medications must be given, etc.)

_____

_____

_____

_____

The personal information on this form is collected under the authority of the School Act, Section 97, and is protected under the *Freedom of Information and Protection of Privacy Act*. The personal information will be used only for the purpose of administering medication to students and may be shared with public health or the Ministry of Social Services. If you have questions about the use and protection of this information, please contact the Information & Privacy Coordinator, Nanaimo Ladysmith Public Schools, 395 Wakesiah Avenue, Nanaimo, B.C. V9R 3K6, or telephone (250) 754-5521.

Revised December 2016

Please read the policy and procedure on pages 3 and 4, and then choose Option A or Option B:

Option A

I request that the staff give medication as prescribed on this form to my child:

_____

Child's Name

- *I agree to supply the medication to the school in the original container with the child's names and the pharmacist's direction for use including dosage, and I will replace expired medications as required.*
- *If changes occur I will contact the school and provide revised written instructions. I am aware that I am required to update this information if medication or dosage changes.*
- *I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.*
- *I am aware that staff working with my child may need to know of my child's condition and of the medication required.*

_____ _____

Parent/Guardian Signature *Date*

Option B

_____ **is capable of:**

- *keeping medication in a secure place*
- *not sharing medication with others*
- *correctly self-administering the medication*

I will make school staff aware of any changes in medication and/or any side effects which would affect school performance or behaviour.

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Student Signature *Date*

Each school staff member who is responsible for the administration or supervision of the medication must review the information on this card, then date and sign below:

Date	Signature	Initials	Comments