Form A

Administration of Medications

(Section 1 - for Completion by Parent/Guardian; Section 2 - for Completion by Physician)

Section 1

For Completion by Parent/Guardian

Student Name:_____D.O.B:_____
(Please Print) **MM / DD / YYYY**

Address: _____

_____

Parent/Guardian Name: _____
(Please Print)

Home Telephone #: _____Cell #: _____

Emergency Contact(s): _____
(Please Print)

Home Telephone #: _____Cell #: _____

School: _____

School Year: _____

Grade/Level: _____ Room/Class:_____Teacher: _____

MCP Number:_____

Medication and Treatment (emergency and non-emergency):

I request and authorize NLSchools to administer the prescribed medication and or emergency medication, or the treatment as described below to the above-named student. I release the Government of Newfoundland and Labrador and any staff member from any legal liability that may result from the administration of such medication or treatment. I also agree to indemnify the Government of Newfoundland and Labrador against claims at any time made by the student or by any other party arising out of the administration to the above-named student of such medication or treatment.

I further acknowledge that school staff members administering the medication or treatment are not medically trained personnel.

Parent / Guardian Permission

_____ Date: _____

Signature of Parent/Guardian **MM / DD / YYYY**

Collection of the personal information requested on this form is under the authority of the Schools Act, 1997 and its use will be for the general purpose of administering educational programming and support services. Treatment of this information will be in accordance with the privacy protection provisions of the Access to Information and Protection of Privacy Act. For additional information on the collection and use of this information, contact the school principal.

Section 2
For Completion by Physician

1. Does the above-named student require this medication/procedure administered/performed during school hours in order to attend school?

☐ YES ☐ NO If yes please describe below:

TYPE OF IN-SCHOOL INTERVENTION NECESSARY: Administration of

Required medication? ☐ YES ☐ NO

Emergency medication? ☐ YES ☐ NO

2. Medication(s) Required (Non-Emergency)

Non- Emergency Medication	Dose and Frequency	Time and method	Purpose of Medication

3. Medication(s) Required (Emergency)

Emergency Medication	Dose and Frequency	Time and method	Purpose of Medication

4. Possible reactions to medication(s)/treatment (symptoms, side effects) and remedial action to medication:

5. Type of storage and safekeeping/storage required for medication:

6. Will it be detrimental to the student's health if a single dose/treatment is omitted?
☐ YES ☐ NO If yes what is the recommended course of action?

7. Does administration of this medication require medical training or certification?
☐ YES ☐ NO If yes please provide details:

8. The above-named student is capable of:
☐ Self-administering* their own medication without supervision by a staff member.
☐ Keeping their own medication in their possession for this purpose.

***If student is to self-administer, a parent/guardian will need to complete Form: Student Self- Administration of Medication.**

COMMENTS:

Name of attending physician (Please Print) Phone number(s)

_____ Date: _____

Signature of attending physician **MM / DD / YYYY**

SCHOOL USE ONLY

- ☐ Form D (Student Self-Administration of Medication) has been received, if applicable.
- ☐ Department forms for Anaphylaxis Management have been completed, if applicable.
- ☐ Department forms for Diabetes Management have been completed, if applicable.

The request is hereby granted, and medication will be administered to

_____

in accordance with the information provided.

Principal's Name: _____

Principal's Signature: _____

Date: _____
MM / DD / YYYY

Note: The original copies of Forms A, D, and Department Forms are to be maintained in the student's Confidential File.

Form B

Student Self-Administration – Administration of Medication Consent and Release Form
(To be completed by Parent/Guardian)

Daily Record of Medication Administration
(This Form should be stored in the same location as the student's medication)

Student Name:_____ Parent/Guardian Name(s): _____

Home Address: _____ Home Tel.#:_____Work Tel.#(s):_____

Attending Physician: _____ Telephone #'s: _____

Physician's Address: _____ Medication(s): _____

Date	Amount/Dose of Medication	Method of Administration	Time Given	Staff Signature	Witness	Comments/ Observations

Form C

School year: _____

School Medications and Procedures: School Office Record (Filed in the School's Main Office)

School:_____**Grade Level:**_____ **Teacher:** _____

Student's Name	Physician's Name & Phone Number	Medication (Qty. in Storage)	Reason for Medication	Dosage	Time(s) Medication to be given	Parent/Guardian	Business / Home Telephone #s	Emergency Contact #s

Form D

Student Self-Administration – Administration of Medication Consent and Release Form
(To be completed by Parent/Guardian)

Student Name:_____ D.O.B:_____
Please Print **MM / DD / YYYY**

Address:

_____

_____

Parent/Guardian Name: _____
(Please Print)

Home Telephone #: _____ Cell #: _____

Emergency Contact(s): _____
(Please Print)

Home Telephone #: _____ Cell #: _____

School: _____

School Year: _____

Grade/Level:_____ Room/Class:_____ Teacher: _____

Prescribed Medication*:

I consent to the above-named student administering their own medication as described in Form: Administration of Medications. I release the Government of Newfoundland and Labrador and any staff member from any legal liability with respect to the self-administration of medications by the above-named student. I also agree to indemnify the Government of Newfoundland and Labrador against claims at any time made by the student or by any other party arising out of the self- administration of medications by the above-named student.

I have discussed the importance of the responsible security and handling of this medication with the student.

_____ Date: _____
Signature of Parent/Guardian **MM / DD / YYYY**

The personal information requested on this form is collected under the authority of the Schools Act, 1997 and will be used for the general purpose of administering educational programming and support services. This information will be treated in accordance with the privacy protection provisions of the Access to Information and Protection of Privacy Act. For additional information on the collection and use of this information, contact the school principal.

FOR SCHOOL USE ONLY

☐ Form A (Administration of Medications) has been received.

☐ Department forms for Anaphylaxis Management have been completed, if applicable.

☐ Department forms for Diabetes Management have been completed, if applicable.

The request is hereby granted and is approved to self-administer medications as described in Form: Administration of Medications.

Teacher(s) Notified re Self-Administration: ☐ YES ☐ NO

Date Notified: _____
MM / DD / YYYY

Principal's Name: _____

Principal's Signature: _____ Date: _____
MM / DD / YYYY

Note: The original copies of Forms A, D, and Department Forms are to be maintained in the Student's Confidential File.