Appendix B

HAMILTON WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- PHYSICIAN/NURSE PRACTITIONER FORM

Part I **To be completed by the attending physician and/or nurse practitioner when medication is initiated or changed.**
(Please type or print)

Student's Name: _____ Birthdate: _____

Address: _____ School: _____

This is to advise that I have prescribed the administration of the following medication listed below for those days when the above-mentioned student is in school **and/or school related board activities**:

1. Name of Medication _____

   Method of Administration _____

   Dosage _____ Time(s) _____

2. Expected date of discontinuation: _____

3. Must the medication be taken during school hours? _____

4. Contra-indications to giving medication: _____

5. Please specify possible hazards or side effects of medication:

   _____

   _____

6. Action to be taken should a reaction occur: _____

   _____

7. Allergies which should be noted (if applicable): _____

   _____

8. Additional instructions (e.g., storage of medication, etc.):

Physician/Nurse Practitioner Name: _____ Telephone: _____

Address: _____

Physician/**Nurse Practitioner** Signature: _____ Date: _____

IS-96-56 (To be placed in Documentation File of O.S.R).

Appendix C

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- ADULT STUDENT/PARENT/GUARDIAN FORM

PART II -<u>To be completed by Adult Student/Parent/Guardian when medication is initiated, changed, *and* annually at the beginning of each new school year.</u>

This is to authorize the administration of the medication(s) prescribed by the attending physician/nurse practitioner from _____ to _____ for:
date date

Student's Name: _____ Birthdate: (yyyy/mm/dd) _____

School: _____

Medic Alert I. D.: Yes _____ No _____

- I give permission for my child to self-administer the medication prescribed by the attending **Health Care Provider**. Yes __ No __
  Signature of Parent/Guardian: _____
  Date:_____
  (Year, Month, Day)

- I release and agree to indemnify the Hamilton-Wentworth Catholic District School Board and its staff from any liability or damages incurred by any party as a consequence of the administration or lack of administration of medication to myself or my child.
  Signature of Parent/Guardian/Adult Student:_____
  Date:_____
  (Year, Month, Day)

NOTE:

- ☐ Parents/guardians/adult students are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS, preferably those in which the medication was supplied from the pharmacist/physician/**nurse practitioner**.
- ☐ The containers should be PROPERLY LABELLED indicating the NAME of MEDICATION, STUDENT'S NAME, ADMINISTRATION DIRECTIONS, **AND EXPIRATION DATE**.
- ☐ The medication will be delivered by parent/guardian/adult student, according to an agreed schedule, to the Principal or designated person for safe keeping, unless otherwise determined.

In case of EMERGENCY, the contact persons are:

Name _____ Name _____

Telephone_____ Telephone _____

Relationship _____ Relationship_____

Under The Municipal Freedom of Information and Protection of Privacy Act, 1989, information in forms and documents pertaining to a student registered/enrolled within The Hamilton-Wentworth Catholic District School Board is collected under the legal authority of The Education Act, and its Regulations, and the Ontario Student Record (O.S.R.) Guideline, 1989. This information is being collected to ensure that the educational program which is provided meets your child's needs.