Medicine Hat Public School Division

601-1st Avenue SW, Medicine Hat, AB T1A 4Y7 | Phone 403.528.6700 | Fax 403.529.5339 | www.mhpsd.ca

MEDICINE HAT PUBLIC BOARD OF EDUCATION OPERATES AS MEDICINE HAT PUBLIC SCHOOL DIVISION,
AND FOR THE PURPOSE OF THIS DOCUMENT WILL BE REFERRED TO AS "MHPSD" AND/OR "DIVISION"

SECTION 600 – Students

ADMINISTRATIVE PROCEDURE - EXHIBIT: REQUEST FOR SCHOOL ASSISTANCE TO ADMINISTER MEDICATION

EXHIBIT CODE:	*626 E 001*
Policy Reference: 626 – Administration of Medication and Medical Care	**Procedure Code Reference:** 626 AP 001– Administration of Medication and Medical Care

EXHIBIT
See below for Exhibit.

REFERENCES
Freedom of Information and Protection of Privacy (FOIP) Act
Health Information Act

Approved: December 17, 2013
Revised: May 11, 2020

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Request for School Assistance to Administer Medication

This form is to be completed if a student's attendance at school requires that medication be administered at the school with or without the assistance of school staff. Completion of this form and authorization by the school principal is required in all instances. This form must be completed when a student registers at a school and permission, if granted, may not be transferred from one school to another without the receiving principal's approval. The information gathered in this form must be reviewed (and confirmed or updated) annually or sooner if the student's condition changes as long as the student is in continuous registration at the school where this permission has been granted.

Please note:

- Copies of this information must be kept in a central and accessible location for access in case of emergency, while maintaining the privacy of the student.
- Medication must be in the original, labelled container.
- Auto-injectors and rescue inhalers must be kept in locations which are easily accessible (not locked in cupboards or drawers) but out of reach of children. The locations should be known to all staff members.

STUDENT INFORMATION

(To be completed by Parent/Legal Guardian or Independent Student)

Date:
Student's Name:
Parent/Guardian Name and Contact Information:
Name of Medication:
Dosage/required:
Purpose of medication:
Time(s) and method of administration:

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Termination date of administering medication:
Medication storage requirements:
Possible adverse reactions:
Procedures in case of adverse reactions:
Disposal procedures for unused medication (confirm with parent/guardian before enacting):

The information you provide will be held in confidence to assist school staff in responding appropriately to the medication management needs of your child. All information placed in a student's file will be protected and used in compliance with the Freedom of Information and Protection of Privacy (FOIP) Act and the Health Information Act (HIA).

I hereby request and give my permission for school staff to administer the medication prescribed on the reverse side of this form to my child, based upon the information contained therein. I make this request knowing that the school staff are not licensed medical personnel and have no special training or limited training in the administration of medication. I am aware of the risks or benefits of consenting or refusing to consent to this treatment. If approval to administer medication is granted, I agree to promptly advise the Principal of the school of any change in my child's medical condition or medication, to provide a sufficient supply of medication in its original container or packaging and accept full responsibility to ensure the safe transportation of these medications to the school.

I acknowledge that I have read and understand why I have been asked to complete this form and understand the board's policy respecting the administration of medication.

I acknowledge that my request, if granted, will be valid for the remainder of the school year in which it is submitted, unless otherwise withdrawn by myself in writing.

I hereby acknowledge that, at my request, school staff have been authorized to administer the prescribed medication in accordance with the directions I have provided.

_____

Name of Parent/Guardian or Independent Student (please print)

_____ _____

Signature of Parent/Guardian or Independent Student Date

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Principal's Approval (in accordance with Policy 626: Administration of Medication and Medical Care)

_____	_____
Name of Principal (please print)	School
_____	_____
Signature of Principal	Date