OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Self-Administration of Oral Medication Authorization

(References: P.108.SCO, PR.548.SCO and PR.632.SCO)

NOTE: Please type and submit the original, signed copy to your child's school principal in a timely manner. In the case of ongoing serious medical conditions (such as but not limited to severe, life-threatening allergies, diabetes, epilepsy, heart condition, asthma), this authorization will terminate on June 30 of each school year. Please ensure to notify the principal if the prescription changes or expires. This authorization may be cancelled upon receipt of written notification to the principal.

School Name:_____ Date: _____

Principal's Name:_____ Teacher's Name: _____

ADVISEMENT OF ADMINISTRATION OF ORAL MEDICATION

Student's Name:_____ Student No.: _____

Parent/Guardian (if student is under 18 years of age): _____

Telephone (Home):_____ Telephone (Business): _____

Address: _____

E-mail Address: _____

Physician's Name:_____ Physician's Telephone: _____

PHYSICIAN'S STATEMENT RE: ADMINISTERING ORAL MEDICATION DURING SCHOOL HOURS

In my opinion, it is necessary that the following medication be administered during school hours:

1. Name of Medication: _____
2. Storage Cautions, if any: _____
3. Dosage of Medication: _____
4. Time of Administration: _____
5. Special instructions for Administration: _____
6. Duration of Medication Regime: _____
7. Caution of Notable Side Effects: _____

Physician's Signature:_____ Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: SELF-ADMINISTRATION

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on the part of the student. By requesting and consenting to the self-administration of medication, you are assuming the risk of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring may be reduced by carefully following the instructions provided by the physician and/or pharmacy at all times. If you consent to the self-administration of medication, you must understand that you will bear sole responsibility for any physical reaction that might occur.

I have read the above and I understand that in requesting and consenting to the self-administration of

medication, I am assuming the risks associated with doing so.

Name of Medication:_____Prescription No._____

The parent (s)/guardian (s) of: _____

hereby consent that the above medication shall be self-administrated by the student in accordance with the procedure outlined above by the physician.

Parent/Guardian Signature (or student if 18 years or older):_____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO RELEASE

I/we give consent for school staff to use and share the information provided in this form as required to attend to the education, health and safety of myself/my child. This may include:

- The pertinent information contained within will be shared with the Ottawa Student Transportation Authority and applicable contracted bus operators (including your child's bus driver where appropriate);
- Posting of the student's photograph (physical and/or electronic) in the school so that all staff, volunteers and visitors are aware of the medical condition;
- And any such other circumstances that may be necessary to ensure the health and safety of your child.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO TRANSFER TO HOSPITAL

I/we give consent for my child to be transported to a hospital if deemed necessary by school staff, and if necessary, a staff member may also accompany my child during transport. Note: The principal shall decide if an ambulance is to be called.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

The personal information on this form is collected under the authority of the Education Act and will only be used to record parental authorization for the self-administration by the student of the named medication. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18 years of age. If you wish to review this information or have questions regarding its collection, please contact your school principal.

The information collected will be protected against theft, loss and unauthorized use or disclosure.

PRINCIPAL'S ACKNOWLEDGEMENT

I have reviewed the information provided in this form, obtained clarification if required, and acknowledge its receipt.

Principal's Signature: _____

Date: _____

THIS FORM MUST BE COMPLETED IN A TIMELY MANNER, INCLUDE ORIGINAL SIGNATURE(S) AND SUBMITTED TO THE SCHOOL PRINCIPAL.