



# EMERGENCY USE OF AUTO-INJECTOR AUTHORIZATION

## (Section 1)

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

**Note: This page must be completed by the parent / guardian if the principal has determined that it is necessary to equip the school with one or more non-prescribed Auto-Injectors, and the parents/guardians are unable to provide the school with two Auto-Injectors.**

School Name: \_\_\_\_\_ Date: \_\_\_\_\_

Principal's Name: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

### ADVISEMENT OF ADMINISTRATION OF 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: \_\_\_\_\_

### PARENT/GUARDIAN AUTHORIZATION RE: ADMINISTRATION OF A NON-PRESCRIBED AUTO-INJECTOR

I/we, \_\_\_\_\_ the parent(s)/guardian(s) of \_\_\_\_\_ hereby give my consent to the Ottawa-Carleton District School Board (OCDSB), in the event of an emergency and in the circumstances that a *prescribed* Auto-Injector is not readily available or not provided to the school, to administer a non-prescribed epinephrine auto injector on my child, which contains a dose of:

- 0.15mg of epinephrine
- or
- 0.30mg of epinephrine

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 either the part of the student or the Ottawa-Carleton District School Board (OCDSB) or its employees or agents. By requesting and consenting to the administration of medication by the OCDSB to your child, 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 administration of medication to your child by the OCDSB, you must understand that you and not the OCDSB 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 administration of medication by the OCDSB, I am assuming the risks associated with doing so.

It is acknowledged that the employees or agents of the OCDSB are not medically trained to administer medication.

**Parent/Guardian Signature (or student if 18 years or older):** \_\_\_\_\_

**Date:** \_\_\_\_\_

## EMERGENCY USE OF AUTO-INJECTOR AUTHORIZATION (General Authorizations- Section 2) (References: P.108.SCO and PR.548.SCO)

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### 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.