OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Serious Medical Conditions
Protocol Registration

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

NOTE: Please type or print neatly and submit the original, signed copy to your child's school principal in a timely manner. This authorization will terminate either on June 30 of each school year or upon notice of when the prescription changes or expires.

School Name: _____ Date: _____
Principal's Name: _____ Teacher's Name: _____
Student's Name: _____ Student No. : _____
Year/Grade _____
Pick-up and Drop-off Bus Route Numbers (if applicable): _____
Transportation Address: _____

STUDENT PHOTO: PLEASE ATTACH A RECENT PHOTO OF STUDENT TO FORM

MEDICAL CONDITION

☐ Epilepsy ☐ Heart Condition ☐ Pace Maker ☐ Asthma
☐ Other (specify):

SYMPTOMS AND WARNING SIGNS (To be completed by parent/guardian):

_____
_____
_____

COURSE OF ACTION (To be completed by parent/guardian):

_____
_____
_____

MEDICATION TO BE ADMINISTERED (if required):

(Administration of Oral Medication Authorization OCDSB 286 and/or Self-Administration of Oral Medication Authorization OCDSB 285 must be completed, signed and on file with the school principal.)

_____
_____
_____

CALL PARENTS/ GUARDIANS:

Parent/Guardian: _____
Telephone (Home): _____
Alternate Telephone Number: _____

OR
Parent/Guardian: _____
Telephone (Home): _____
Alternate Telephone Number: _____

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 administration of the named medication to the student by Board staff. 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, please contact the school Principal.