(Policy IHCD)
MEDICATION/PERSONAL CARE REQUEST AND AUTHORIZATION - Page 1

Name of Child _____ Birthdate _____

Address _____ Home Telephone _____

Father/Guardian-work telephone _____ Mother/Guardian-work telephone _____

Name of Medication _____

Personal care required _____

_____

Purpose of medication/personal care _____

_____

_____

** Name of Doctor _____ Doctor-telephone _____
** Where procedures beyond a written prescription are required, written instructions from the doctor shall be attached.

The time(s) medication/personal care is to be given _____

Dosage and/or related instructions _____

_____

Possible side effects _____

_____

Termination date of medication/personal care _____

Emergency procedures to be implemented No _____ Yes _____ (See reverse)

Detail of Emergency Procedures:

_____

_____

_____

_____

_____

_____

_____ _____

Physician's Signature Date

Freedom of Information and Protection of Privacy – Disclosure Sec. 32

The personal information requested on this authorization form is being collected to determine the specific medication and personal care for your child, requested of the school. The information will be made available on a need to know basis to people who are working with your child and providing the required care. The information is collected pursuant to the *School Act* and Regulations thereto. It will not be disclosed to any other person or organization except as authorized by the *Freedom of Information and Protection of Privacy Act.* If you have questions about the collection and use please contact the principal of the school your child attends or the Assistant Director, Special Needs, Elk Island Public Schools, Sherwood Park, Alberta at 417-8223.

I hereby request and give my permission for the below-named school to administer medication prescribed on the form to my child. I make this request in the knowledge that school personnel have no special training or limited training in the administration of the medication. Parents/guardians must inform the principal of any changes in the administration of the medication. A new request/authorization form must be completed and given to the principal.
In addition, I accept responsibility to ensure the safe transportation of these medications to the school. I hereby acknowledge that at my request the principal or her/his designate has been authorized to administer the prescribed medication:

NAMELY: _____

TO MY SON/DAUGHTER/WARD: _____

DATE OF BIRTH: _____ CLASS: _____

SCHOOL: _____

And I hereby release the principal and/or his designate and Elk Island Public Schools from any claim for harmful effects resulting from the administration of the prescribed medication and I hereby agree to indemnify and save harmless the principal and/or his designates and Elk Island Public Schools from all claims that may result therefrom. I have received a copy of the Board's policy on the administration of medication, and agree to follow the policy.

_____
(Name of Parent/Guardian)

_____ _____
Signature of Parent/Guardian) Date

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SCHOOL USE

Location where medication/personal care supplies are kept _____

Person administering medication/personal care _____

Alternate person(s) _____