SCHOOL DISTRICT No. 69 (QUALICUM)

APPENDIX IX - STUDENT HEALTH AND COMMON MEDICAL CONDITIONS

RECORDING FORM - REQUEST FOR ADMINISTRATION OF MEDICATIONS

***Note: School District regulations restrict Epi-Pen® use to pre-loaded single dosage auto-injection Epi-Pens®.**

SECTION A: TO BE COMPLETED BY PARENT OR GUARDIAN

Student's Name _____ Birthday (d/m/y) _____

Parent or Guardian _____ Home Phone _____ Work Phone _____

Emergency Contact _____ Emergency Phone _____ Other Phone _____

Physician _____ Clinic _____ Phone _____

SECTION B: TO BE COMPLETED BY PRESCRIBING PHYSICIAN

In my opinion, the following procedures are medically appropriate for the above-named student and should be administered during school hours if needed.

Condition(s) which may make medication necessary: _____

_____

_____

_____

Name of Medication	Dosage/Frequency	Directions for Use

Additional Comments (possible reactions, consequences of missing medication, etc): _____

_____

_____

_____

Physician's Signature: _____ Date: _____

SECTION C: TO BE COMPLETED BY PARENT OR GUARDIAN

I will notify the school promptly of any changes in medication ordered.

Signature of Parent/Guardian: _____ Date: _____

SECTION D: TO BE COMPLETED BY SCHOOL STAFF

Each staff member who is responsible for the administration or supervision of the medication must review the information on this paper, then date and sign below.

Date	Signature	Comments (if any)

PARENT/GUARDIAN INFORMED AUTHORIZATION AND RELEASE

I/We hereby request that the administration of medication/Epi-Pen® be provided. I/We understand that the service will be provided by a person without medical or nursing training. All training will be the parent's responsibility at no cost to the Board. It is further agreed that the student will carry the medication. It is further understand that in the absence of the regular bus driver, a replacement driver may be assigned to this route. The replacement driver may or may not be trained to administer the medication/Epi-Pen®. I/We agree to provide the Board with an updated medical statement whenever there is a change in the physician's instructions with respect to medication/Epi-Pen®.

I/We confirm that the physician named above has fully explained to me/us and my/our child (student named above) the results and affects and possible side-effects of such treatment and hereby acknowledge that I/we have read and fully understand the terms set out herein. I/We have received a copy of the Board's policy and procedures in this regard, and I/we have read and understand their contents and agree to abide by the terms set out.

IN CONSIDERATION of the School Board authorizing certain of its employees to administer he above medication/Epi-Pen® as required in this authorization form, I/WE HEREBY RELEASE AND FOREVER DISCHARGE the Board of Education of School District No. 20 (Kootenay-Columbia), its members, officers, administrators and employees from any and all claims whatsoever and actions or causes of action which I/we may have against the Board, its members, officers, administrators and employees arising out of the administration of the medication/Epi-Pen® referred to in this authorization/release form.

Date: _____

Signature of Parent(s)/Guardian(s): _____

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