# REQUEST TO ADMINISTER MEDICATION OR MEDICAL CARE

*The personal information on this form is collected under the terms of section 33 c) of the Freedom of Information and Protection of Privacy Act (FOIPP). This information will be used only for the administration of medical care as described below. If you have any questions concerning the collection or use of this information, please contact the Treasurer of the Conseil scolaire du Nord Ouest at 780-624-8855.*

## INFORMATION

Student Name: _____ Date of Birth: _____

Health Insurance Number: _____

Designated medical establishment / hospital and/or name and phone number of physician: _____

## PARENT/GUARDIAN CONTACT INFORMATION

Name of legal parent(s)/tutor(s) : _____

Legal address: _____

Telephone : Home _____

Cell (mother) _____ Work (mother) _____

Cell (father) _____ Work (father) _____

## ALTERNATE CONTACT (IN CASE OF EMERGENCY)

Name: _____ Telephone : _____

Legal address: _____

## PARENTAL REQUEST

I, _____ , authorize the personnel of _____

Name of parent/guardian — Name of school

to administer medicine or medical care to: _____

Name of Student

| Name of medication | Dose | Frequency |
|---|---|---|
| | | |

☐ A copy of pharmaceutical information (including a description of side effects) has been provided to the school.

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- ❑ I acknowledge having read and understood CSNO Administrative Directive 313.
- ❑ I confirm that, according to the physician, the prescribed medication cannot be taken outside of school hours (before or after school).
- ❑ I agree to provide the school with the medication prescribed by the physician in its original packaging with the pharmacy label.
- ❑ I also acknowledge and accept that the school administration or the designated person reserves the right to refuse to administer medication to a student if the requested necessary information has not been provided.
- ❑ I confirm that the student's physician has recommended that the medication be taken during class hours.
- ❑ I acknowledge that school staff do not have medical training to administer medication, and I release the Board, its representatives, and the school staff from any civil liability arising from the administration of the medication.
- ❑ I also agree to notify the school in writing of any changes (including discontinuation of medication) and of any prescription renewals.

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|---|---|
| **Date** | **Signature of Parent/Guardian** |