CHILD/STUDENT MEDICATION/PERSONAL CARE MANAGEMENT PARENT/GUARDIAN CONSENT

Child/Student Name _____

Approval

I request that Westboro Elementary (K-6)

(School Name)

staff administer/monitor my child's medication as outlined in the attached Child/Student Medication Management Plan and/or the Student Personal Care Management Plan for my child. I make this request in the knowledge that school personnel may have no special training or limited training in the administration of the medication/personal care. I must inform the principal/designate of any changes in the administration of the medication/personal care and a new Child/Student Medication Management Plan and/or Child/Student Personal Care Management Plan form must be completed.

I will give the schools the physician prescribed medication in its original container with the current pharmacy label attached. The medication dose schedule has been planned such that a minimum number of doses will be give at school. Medication/Personal Care supplies and refills will be supplied to the school when necessary.

I accept responsibility to ensure the safe transportation of medications/personal care supplies to the school. I hereby acknowledge that the principal/designate has been authorized to administer the prescribed medication/personal care and I hereby release the principal/designate and Elk Island Public Schools from any claim for harmful effects resulting from the administration of the prescribed medication/personal care. I hereby agree to indemnify and save harmless the principal/designate and Elk Island Public Schools from all claims that may result.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

Principal/Designate Signature	Date

Freedom of Information and Protection of Privacy - Sec. 33/34

The information collected on this form is for the purpose of administering medication/personal care arrangements for your child/student. This personal information is collected pursuant to the provisions of the *School Act* and Regulations thereto, and the *FOIP Act*. If you have any questions about the collection and use of the information, please contact the principal of the school or the Associate Superintendent, Instructional Services, Elk Island Public Schools, Sherwood Park, Alberta, at 780-417-8227.

Elk Island Public Schools

CHILD/STUDENT MEDICATION MANAGEMENT PLAN

This plan is intended for physician prescribed medications including PNR and over the counter medications. For all children/students with severe allergies and anaphylaxis also complete the **Anaphylaxis Emergency Plan** form. This form **must** be accompanied by a signed **Child/Student Medication/Personal Care management Parent/Guardian Consent** form.

Child/Student Name _____

Medication Information - Do not use abbreviations. Update annually. Medication **must** be received in original container.

	Medication #1 ☐ Monitor ☐ Administer ☐ Pharmacy information sheet is provided	**Medication #2** ☐ Monitor ☐ Administer ☐ Pharmacy information sheet is provided
Medication name		
Therapeutic effect(s)		
Possible side effect(s)		
Plan of action for possible side effect(s)		
Dose		
Route of administration (e.g. by mouth)		
Time(s) to be administered		
Start date of medication		
Finish or review date		

Complete During Meeting

Medication location for administering/monitoring		
Name of staff member administering/monitoring		
Alternative staff member administering/monitoring		
Special instructions		

Approval

_____ _____

Parent/Guardian Signature Date

_____ _____

Principal/Designate Signature Date

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