ANNAPOLIS VALLEY REGIONAL SCHOOL BOARD
Administration of Prescribed Medication to Students

SECTION 1 – TO BE COMPLETED BY PARENT(S)/LEGAL GUARDIAN(S)

Student Information

Name: ___________________________________ DOB (dd-mm-yyyy): _______________________

Address: ____

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Parent(s)/Legal Guardian(s) ____

Phone (H): ________________________ HCN: ____

School: ____________________________ Grade/Homeroom Teacher: ________________________

Emergency Contacts

Name: ___________________________ Phone Number(s): __________________________________

Name: ___________________________ Phone Number(s): __________________________________

Name: ___________________________ Phone Number(s): __________________________________

I hereby request, authorize and empower the Annapolis Valley Regional School Board to administer medication as described herein to the student named above. I release any staff member and the Annapolis Valley Regional School Board from any legal liability that may result from the administration of such medication. I also agree to indemnify the Annapolis Valley Regional School Board against claims at any time made by the student named or by MSI arising out of the administration of medication described herein. I understand that the dosage of medication typically be limited to a one month supply and that I am responsible for completing this form in the event that the prescribed medication, amount or frequency of dosage, handling or storage requirements change.

I acknowledge and understand that as a parent/legal guardian I am responsible to ensure there is medication in sufficient amount and dosage to meet the needs of the student every day the student is in school and requires the medication to be administered. I also understand and agree that if there is insufficient medication at the school I will be contacted to make arrangements to transport new medication to the school, or to make alternate arrangements for the care of the student for the remainder of the school day. I hereby release any staff member in the Annapolis Valley Regional School Board from any legal liability that may result from insufficient amounts of medication being available at the school for administration to the student.

____ ____

Parent/ Legal Guardian Name (Please Print) Parent/Legal Guardian Signature

Dates of Authorization: From ________________ to _______________ Date: ______________________________

SECTION 2 - TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Name of Student: ____

Reason/name of medical condition(s) requiring medication to be given during school hours:

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Note: Where possible parent(s)/legal guardian(s) are asked to establish a schedule for the administration of medication outside of the school day.

	Medication #1	Medication #2	Medication #3
Name of Medication			
High Alert	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Required Intervention	☐ Administer by staff ☐ Self administer with staff monitoring ☐ Self administer	☐ Administer by staff ☐ Self administer with staff monitoring ☐ Self administer	☐ Administer staff ☐ Self administer with staff monitoring ☐ Self administer
Dose of Medication			
Frequency			
Time(s) medication is to be given during school hours			
Route			
Possible side effects			
Course of action in response to side effect(s)			
Storage requirements of medication			

Duration of treatment (start-finish date)			
Date when medication first prescribed			
Symptoms of overdose and suggested course of action			
State the course of action in the event that a dose is missed			
Is special training required to administer the medication?	☐ **Yes** ☐ **No** **If yes please obtain and complete a Student Health Partnership Referral Form**	☐ **Yes** ☐ **No** **If yes please obtain and complete a Student Health Partnership Referral Form**	☐ **Yes** ☐ **No** **If yes please obtain and complete a Student Health Partnership Referral Form**

______________________________ ______________________________

Parent/Legal Guardian Signature Date

Definitions:

High Alert Medication:	Medication that when used in error, has an increased risk for causing significant harm to one's body; serious medical consequences could result from failure to administer the medication(s) according to an exact schedule or specific manner prescribed.
Route:	The path by which the medication enters the body.
Non-Prescription Medication:	Medication that does not require a physician's authorization.
Correction Bolus:	A spurt of insulin delivered quickly to bring a high blood sugar back within a person's target range for before a meal, after a meal, or a bedtime.

Near Miss:	An event or circumstance with the capacity to cause harm which has been detected and corrected before reaching the student. This "good catch" or "near miss" may not have reached the student due to chance, corrective action and/or timely intervention.
Prescription (RX):	Medication that can be purchased or given out only with written instructions from a licensed health care provider.
Carb Bolus:	A spurt of insulin delivered quickly to match carbohydrates in an upcoming meal or snack