Appendix A ADMINISTRATION OF PRESCRIBED MEDICATION

This form is to be completed for a pupil who requires medication during school hours to be able to attend school. This personal information and personal health information is being collected, used, and disclosed to school staff or to agents of the Board in accordance with the Personal Health Information Protection Act, Municipal Freedom of Information and Protection of Privacy Act, the Education Act, Sabrina's Law, 2005 and Ryan's Law, 2015 for the purpose of administering medication. Please type or print clearly.

PUPIL: _____ BIRTHDATE: _____

ADDRESS: _____ SCHOOL: _____

TO BE COMPLETED BY PHYSICIAN AS REQUESTED BY THE MEDICAL OFFICER OF HEALTH:				
Reason For Medication:	Specific Requirements for Administration and/or Storage:		Date:	
Medication Prescribed:	Amount/Dose At Each Time	Time of Each Dose	Beginning Y/M/D	Ending Y/M/D

Is it appropriate for staff or agents of the Board as appropriate to administer this medication? Yes ___ No ___
Is there any training required for staff with respect to the administration of this medication? Yes_____ No ____
Additional Information Attached: Yes _ No _
Physician's Name: _____ Telephone: (___)_____
Physician's Signature: _____ Date: _____
I approve the use of non-prescription topical creams, such as sunscreen, which may be required to allow a student to attend school and participate in events (in the case where a student cannot apply the cream themselves due to a developmental or physical disability) to be applied by staff. Physician's initials_____

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TO BE COMPLETED BY PARENT:

- I/We understand that the decision to permit an employee of the Peel District School Board or an agent of the Board to administer medication to my son/daughter is a personal, family decision.
- I/We request the administration of medication as prescribed during school hours and hereby consent to the disclosure of the above personal health information to the Peel District School Board, agents of the Board as appropriate and the Regional Health Department.
- I/We accept the responsibility to hand deliver to the school the medication in the original container from the pharmacy and the instructions to the school.
- I/We acknowledge that the administration of medication by employees or agents of the Board who are not health professionals is being undertaken in the best interests of the students as an accommodation and as such constitutes a risk to the student of possible loss, damage or injury.
- I/We permit the Peel District School Board to contact the signing physician if clarification of the instructions is required.
- I/We have been advised that neither the Peel District School Board nor its employees or agents of the Board will accept responsibility for any loss, damage or injury to my child or his/her family, property arising out of the administration or failure to administer the medication described above.

DATE: _____ PARENT/GUARDIAN'S SIGNATURE: _____
PHONE - HOME: (___)_____ BUSINESS: (___)_____

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I have reviewed the above request and support that it follows the guidelines provided by the Medical Officer of Health.
DATE: _____ PRINCIPAL'S SIGNATURE: _____
c: OSR