

Form ADMIN 320-01 Parent Request and Authorization

**PARENT REQUEST AND AUTHORIZATION
FOR STAFF ADMINISTRATION OF MEDICATION and/or MEDICAL PROCEDURES
MOOSE FACTORY ISLAND DISTRICT SCHOOL AREA BOARD
MINISTIK PUBLIC SCHOOL**

Ontario Education Number (OEN): _____

Name of Student: _____ Teacher: _____

Address: _____

Home Telephone Number: _____ Birth Date: _____

PARENT'S/GUARDIAN'S APPROVAL

I hereby request and give permission for Ministik Public School to administer medication and/or provide medical procedures prescribed herein to my child who is named above, for this school year or the duration indicated by the physician on Form ADMIN 320-02 Parent Release of Medical Information, whichever is less. **I understand that the medication will be administered and/or medical procedures provided by staff members of Moose Factory Island District School Area Board who are not trained medical professionals, but who are lay persons who are administering such medication(s) or medical procedures at my request.**

Parent's/Guardian's Signature: _____

Date Signed: _____

The personal information contained in this form is collected under the authority of the *Education Act* and protected under the authority of the *Municipal Freedom of Information and Protection of Privacy Act* and will be used to administer medication and to provide information that may be required in medical or other emergencies.

If you have any questions about this form call _____
(Principal)

at _____

Form ADMIN 320-02 Parent Release of Medical Information

A. PARENT'S RELEASE OF MEDICAL INFORMATION (to be completed by parent/guardian)

NAME OF STUDENT: _____ D.O.B. _____

Address: _____

Telephone # Home: _____ School: **Ministik Public School**

Parent/Guardian Signature: _____

B. PHYSICIAN INFORMATION (to be completed by physician)

NAME OF PHYSICIAN: _____ Telephone # _____

NAME OF MEDICATION: _____

Form of medication: Tabs/caps: _____ Liquid: _____ Inhaler: _____

Please verify that this medication cannot be taken outside school hours: _____

Amount to be given at school: _____

Duration: _____

Please clearly indicate procedures to be followed in administering medication(s) or medical procedures and any training available to lay persons which might assist board staff members:

Physician Signature: _____ Date: _____

C. PHYSICIAN or PHARMACIST INFORMATION

Storage (if other than secure, dry storage): _____

Potential Side Effects: _____

Action to be taken, if side effects: _____

Physician Signature: _____ Date: _____

or

Pharmacist Signature: _____ Date: _____

Pharmacist Address: _____ Phone: _____

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If you have any questions about this form call: _____ (Principal)
at _____

Form ADMIN 320-03 Administration of Medication Monthly Log

<p>Reminder: Administration Checklist (on log)</p> <ol style="list-style-type: none"> 1. Compare the information recorded on the request for administration with the pharmacy label on the medication container. 2. Check the expiry date on the medication. 3. Confirm student's surname and first name. 4. Record each occasion when medication is given. 5. Record dates when student is absent 	<p>AFFIX CURRENT PHOTO OF STUDENT HERE</p>
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**MOOSE FACTORY ISLAND DISTRICT SCHOOL AREA BOARD
STAFF ADMINISTRATION OF MEDICATION MONTHLY LOG
(Administrative Procedure 320)**

NAME OF STUDENT _____ **DATE OF BIRTH** _____

Date	Time	Medication	Dosage	Signature of Person Administering	Comments

Form ADMIN 320-04 Person Responsible for Procedure

PERSON RESPONSIBLE FOR PROCEDURE

I have agreed to be responsible for the administration of medication(s) and/or medical procedures

[Please describe]

as requested by _____
(parent/guardian)

The administration will occur in **Ministik Public School**. The medication(s) and/or medical procedures have been indicated by the physician _____

I agree to maintain a log of the administration of this medication and/or medical procedure. I understand that I am performing this procedure under the principle of “in loco parentis” and not as a health professional.

Date

Signature

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