AP Appendix 3204: Request for Medication at School Form

School: _____

Date: _____

Parent/Guardian Name: _____

Student Name: _____

Medication Required While Attending School:

_____

_____

Frequency and Dosage: _____

Duration: _____

Medical Procedure Required:

_____

_____

_____

Training Required: Yes: _____ No: _____

If yes, date of training: _____

Physician/Medical Personnel Signature: _____

Public Health Nurse: _____

Attending School Personnel, including position:

_____

_____

I authorize the administration of required medication to my child by the personnel named above. I sign this release absolving the School District No. 8 (Kootenay Lake) Board of Trustees, the school and the personnel named from any and all liability arising from the administration of the medication or the performance of the medical procedure required.

Signature: _____ Date: _____

Related Policy: Nil
Related Administrative Procedure: 200.2 Student Medication
Revised: August 22, 2018

**AUTHORIZATION/RELEASE FOR ADMINISTRATION
OF EMERGENCY MEDICATION AT SCHOOL**

I/We _____, the parent(s)/legal guardian(s) of

_____, confirm that it is necessary for my child

to receive the following medication at school for his/her medical condition:

_____

_____
(set out medication required)

I/WE HEREBY REQUEST that the above medication be administered in emergency situations by school staff

to _____in the following manner:

(I understand the school prefers to receive day medication in an appropriately labelled blister pack.)

_____

_____

_____
(here specify manner of administration, e.g. orally, external application, injection, and specify the daily administration times, if any)

Student Emergency Plan: "If prescribing epinephrine emergency medication, it must be a single dose, single-use auto-injector for school setting with a second injector which can be given 10 – 15 minutes if symptoms do not improve. An oral antihistamine will not be administered by school personnel."

IN CONSIDERATION of the School Board authorizing certain of its employees to administer the above medication as required in this authorization form, I/WE HEREBY RELEASE AND FOREVER DISCHARGE the Board of School Trustees of School District No. 8 (Kootenay Lake), its members, officers, administrators and employees from any and all claims whatsoever and actions or causes of action which I/we may have against the Board, its members, officers, administrators and employees arising out of the administration of the medication referred to in this authorization/release form.

DATE: _____ _____
Parent(s)/Legal Guardian(s)

ATTENDING PHYSICIAN'S STATEMENT

I, _____, am a qualified doctor licensed to practice in British Columbia. I

am the attending physician to_____ and hereby approve and authorize the

medication and the administration of such medication referred to above.

DATED at _____, B.C. _____

Attending Physician _____ (Signature)