Grasslands Public Schools

OFFICE USE — ASN

FORM-HS-001

PUBLIC

# Authorization for the Administration of Medication

**Notice of collection.** The personal information collected on this form, including the student's health information, is collected by Grasslands Public Schools under the authority of POPA sections 4(a) and 4(c), the *Education Act* SA 2012 sections 33(1)(d) and 33(1)(e), and the *Student Record Regulation*, Alta Reg 97/2019, section 2(1)(p), in support of safely administering medication or a health procedure to the student. This notice is provided in accordance with POPA section 5(2). The information is used to record the medication or procedure the student requires, obtain the physician's and parent's authorization, and respond to the student's medical needs during the school day.

If you have any questions about the collection or use of this information, please contact the Access and Privacy Coordinator at **privacy@grasslands.ab.ca** or 403-793-6700.

## Student information

LEGAL FIRST NAME

LEGAL LAST NAME

BIRTH DATE (YYYY-MM-DD)

SCHOOL

SCHOOL YEAR

GUARDIAN 1 — NAME

RELATIONSHIP

PHONE

GUARDIAN 2 — NAME

RELATIONSHIP

PHONE

This authorization is valid for the school year indicated above only, and must be renewed each year.

## Non-prescription medication requirements

| NAME OF MEDICATION | DOSAGE | FREQUENCY | TIME OF DAY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

MEDICATION STORAGE REQUIREMENTS

Does the student need staff assistance? ○ Yes ○ No

IF YES, PLEASE EXPLAIN THE ASSISTANCE NEEDED

## Prescription medication requirements

A physician's signature is required when administering prescription medication (see the Physician's endorsement on the next page).

MEDICAL CONDITION(S) WHICH MAKE THE MEDICATION(S) NECESSARY

MEDICATION(S) WHICH THE STUDENT REQUIRES

## Prescription medication — details

| NAME OF MEDICATION | DOSAGE | FREQUENCY | TIME OF DAY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

MEDICATION STORAGE REQUIREMENTS

Does the student need staff assistance? ○ Yes ○ No

IF YES, PLEASE EXPLAIN THE ASSISTANCE NEEDED

MEDICAL OR THERAPEUTIC PROCEDURE

POSSIBLE SIDE EFFECTS REQUIRING EMERGENCY ACTION

ACTION NECESSARY IF AN EMERGENCY ARISES

ADDITIONAL INSTRUCTIONS OR INFORMATION

## Physician's endorsement

PHYSICIAN'S NAME

PHYSICIAN'S PHONE NUMBER

PHYSICIAN'S LOCATION AND ADDRESS

PHYSICIAN SIGNATURE

DATE (YYYY-MM-DD)

## Parent / legal guardian release

PARENT / LEGAL GUARDIAN NAME

I request and authorize an employee or agent of Grasslands Public Schools to administer the medication, or provide the medical procedure demonstrated by the physician or therapist, to the student named above. This serves as a release and indemnification from any action or inaction of School Division personnel associated with administering the medication or performing the requested health procedure as specified and demonstrated by the medical practitioner noted above. I recognize and acknowledge that the employee or agent who may administer the medication or perform the health procedure is not a medical practitioner.

It is the responsibility of the parent or legal guardian to forward to the school written physician's instructions regarding any changes to the administration of medication (including dosage) or to the specified health procedures.

PARENT / LEGAL GUARDIAN SIGNATURE

DATE (YYYY-MM-DD)