Niagara Catholic District School Board
ADMINISTRATION OF MEDICATION
(When no Individual Student Plan of Care is required)

Personal information on this form is being collected under the authority of the Education Act, in accordance with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA). The purpose of collection is to identify protocols to follow in the event a student experiences symptoms pertaining to a prevalent medical condition. Questions about this collection should be directed to the Superintendent of Education, Student Support, Niagara Catholic District School Board, 427 Rice Road, Welland, ON L3C 7C1, (905) 735-0240.

STUDENT PROFILE and INFORMATION

SCHOOL YEAR _____ to _____

Insert current student photo

Student Name _____
First Name Last Name

Date of Birth _____ Age _____
(MM/DD/YYYY)

O.E.N. _____ Grade _____

School _____

Teacher(s) _____

PARENT(S)/GUARDIAN(S) & EMERGENCY CONTACT INFORMATION

	Name	Relationship	Phone
1.			
2.			
3.			
4.			

PRE-AUTHORIZATION and CONSENT

- ☐ I/We request, give permission and authorize the principal/designate to administer the noted medication, during school hours.
- ☐ I/We understand that it is my/our responsibility to provide the medication in its original pharmaceutical container and the original dispensed quantity of medication supplied by the pharmacist, which is clearly labeled indicating my child's name and administration instructions.
- ☐ I/We understand that it is my/our responsibility to ensure that the school has a supply of medication on hand at any given time. The principal/designate will return any remaining medication at the end of the school year.
- ☐ I/We consent to use, share and disclose personal Information related to my child. Complete the NCDSB Consent to Use, Share and Disclose Personal Information Form.
- ☐ I/We give consent to share my child's photograph on paper notices (binders) or electronic format(s).
- ☐ I acknowledge that I am aware and understand my child's medical condition and the risks associated with its care and emergency treatment, and that the Niagara Catholic District School Board and its staff and volunteers are acting in their role as educators and not health care professionals.

AUTHORIZATION and SIGNATURES

Parent/Guardian Name (Print)	Signature	Date
Parent/Guardian Name (Print)	Signature	Date
Student Name, if older than 18 (Print)	Signature	Date
Principal/Designate (Print)	Signature	Date

Signatures of the parent/guardian, principal, and physician/medical professional signify agreement regarding the procedures and consent to administer the Medication prescribed by the Physician/Medical Professional, that must be administered during the school hours and consent for pertinent medical information concerning the student to be released as required in accordance with the Municipal Freedom of Information and Protection of Privacy Act.

Niagara Catholic District School Board
ADMINISTRATION OF MEDICATION
(When no Individual Student Plan of Care is required)

Personal information on this form is being collected under the authority of the Education Act, in accordance with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Heath Information Protection Act (PHIPA). The purpose of collection is to identify protocols to follow in the event a student experiences a medical emergency. Questions about this collection should be directed to the Superintendent of Education, Student Support, Niagara Catholic District School Board, 427 Rice Road, Welland, ON L3C 7C1, (905) 735-0240.

Student Name		D.O.B. (MM/DD/YYYY)	

Complete one form for each medication, if medication is administered, by staff, during the school day

TO BE COMPLETED BY PHYSICIAN/MEDICAL PROFESSIONAL FOR MEDICATION REQUIRED DURING SCHOOL HOURS	
Medical Condition/ Diagnosis requiring medication	
Name of medication	
Dosage	
Specific Time(s) of day Medication is to be Administered:	
Additional instructions (e.g.. storage)	
Route of administration	
Duration of Doctor's orders	☐ Medication is ongoing **or** ☐ Start Date: _____ ☐ End Date: _____
Possible side effects	
Student can self-administer	☐ YES ☐ NO
Student will self-carry medication	☐ YES ☐ NO

PHYSICIAN/MEDICAL PROFESSIONAL INFORMATION and AUTHORIZATION

Physician/Medical Professional name, address, phone (Stamp accepted)

☐ I confirm that I have prescribed the above medication(s) that must be administered during the school hours as prescribed.

_____ _____
Physician/Medical Professional Signature Date

Signatures of the parent/guardian, principal, and physician/medical professional signify agreement regarding the procedures and consent to administer the Medication prescribed by the Physician/Medical Professional, that must be administered during the school hours and consent for pertinent medical information concerning the student to be released as required in accordance with the Municipal Freedom of Information and Protection of Privacy Act.