

**PARENT/PHYSICIAN/MEDICAL PROFESSIONAL REQUEST FOR STUDENT
SELF-ADMINISTRATION AND STORAGE OF INHALERS/EPIPEN/MEDICATION**

TO BE COMPLETED BY PARENT/GUARDIAN/STUDENT

A. Personal Information

Name of Student: _____ Date of Birth: _____
Day Month Year

Name of Parents: _____

B. Medical Information

Why is this medication required?

Special Instructions (storage, training required for staff involved):

Medication Prescribed: Dose: Time of Administration: AM Noon PM
1. _____
2. _____
3. _____

Duration of Continuing Medication(s): _____

What are the specific side effects to your child? _____

With an increasing number of children on daily medications, it is essential that the above information be known.

I/We understand that the decision to permit an employee of Canadian Independent College to administer medication to my son/daughter is a personal, family decision.

I/we acknowledge that the administration of medication by employees and agents of Canadian Independent College who are not health professionals is being undertaken in the best interests of the students as a service and as such constitutes a risk to the student of possible loss, damage or injury. I/we acknowledge that employees or agents of the Canadian Independent College may in some circumstances be unable to administer the medication described above as required or in a timely manner and may be required to refuse to administer any or all medications requested by me/us to be administered.

I/We acknowledge that neither Canadian Independent College nor its employees will accept responsibility for any loss, damage or injury to my child or his/her property arising out of the administration or failure to administer the medication described above, and I/we agree to release any staff member and the H Canadian Independent College from any legal liability that may result from the administration of or failure to administer medication.

I will complete a revised form if there are any changes or modifications to the administration of my child's prescribed routine medication.

Date:

Signature of Parent/Guardian:

The personal and/or health related information gathered on this form is being collected, retained, used and disclosed in accordance with the Municipal Freedom of Information and Protection of Privacy Act, Education Act and Personal Health Information Protection Act.

Note: This request will terminate on July 1 of each school year.