

Horizon School Division # 67

Policy IHCD Attachment 1

(Request for School Assistance with Administration of Medication Form)

Student ID Number:		Date:	
Student's Legal Last Name	Student's Legal First Name	Student's Legal Middle Name	
Address:	Phone (Home)	Phone (Work and/or Cell)	
Name of Medication:			
NOTE: Medications administered at school <u>MUST</u> be contained within the original prescription container, complete with current label.			
Special instructions for storage of medicine:			
Medical condition(s) which make(s) the medication necessary:			
The medication is to be (check one): ☐ self-administered by student under the supervision of staff member ☐ administered to the student under the direction of a staff member. ☐ used only when the following symptoms appear (describe below):			
Treatment (other than medication) which is appropriate when symptoms appear:			
Possible effects if medication is not administered according to the prescribed schedule:			
Prescribed Dosage:		Frequency of Dosage:	
Starting Date:		Completion Date:	
Name of Parent/Guardian or Independent Student (please print)	Signature of Parent/Guardian or Independent Student	Date:	
Name of Physician	Physician Phone Contact	Physician's or Pharmacist's Signature:	
Name of Principal:	Signature of Principal:	Date:	
Personal information is collected under the authority of the <i>School Act</i> and Alberta's <i>Freedom of Information and Protection of Privacy Act</i> (FOIP). This information will be used to respond to the identified medical need of the student named above. It will be treated in accordance with the privacy protection provisions of the FOIP Act.			