PARENT REQUEST AND AUTHORIZATION
FOR STAFF ADMINISTRATION OF MEDICATION and/or MEDICAL PROCEDURES

MOOSONEE PUBLIC SCHOOL

Ontario Education Number (OEN): ________________________

Name of Student: ______________________ Teacher: ________________________________

Address:
____

Home Telephone Number: _________________ Cell Phone Number: _________________
Birth Date: ______________________________

PARENT'S/GUARDIAN'S APPROVAL

I hereby request and give permission for Moosonee Public School to administer medication and/or provide medical procedures prescribed herein to my child who is named above, for this school year or the duration indicated by the physician on Form ADMIN 330-02 Parent Release of Medical Information, whichever is less. **I understand that the medication will be administered and/or medical procedures provided by staff members of Moosonee District School Area Board who are not trained medical professionals, but who are lay persons who are administering such medication(s) or medical procedures at my request.**

Parent's/Guardian's Signature: ____

Date Signed: __________________________

The personal information contained in this form is collected under the authority of the *Education Act* and protected under the authority of the *Municipal Freedom of Information and Protection of Privacy Act* and will be used to administer medication and to provide information that may be required in medical or other emergencies.

If you have any questions about this form call ___________________________________
(Principal)

at ____

Form ADMIN 330-02 Parent Release of Medical Information

A. PARENT'S RELEASE OF MEDICAL INFORMATION (to be completed by parent/guardian)

NAME OF STUDENT: ________________________________ D.O.B.______________________

Address: ____

Telephone # Home: ___________________________ School: **Moosonee Public School**

Parent/Guardian Signature: ____

B. PHYSICIAN INFORMATION (to be completed by physician)

NAME OF PHYSICIAN: ________________________________ Telephone # ________________

NAME OF MEDICATION: ____
Form of medication: Tabs/caps: _____Liquid: _____Inhaler: _____
Please verify that this medication cannot be taken outside school hours: ________________________
Amount to be given at school: ____
Duration: ____

Please clearly indicate procedures to be followed in administering medication(s) or medical procedures and any training available to lay persons which might assist board staff members:

____

____

____

Physician Signature: ____________________________________Date: ______________________

C. PHYSICIAN or PHARMACIST INFORMATION

Storage (if other than secure, dry storage):____
Potential Side Effects: ____

____

Action to be taken, if side effects: ____

____

Physician Signature: ____________________________________ Date: ____________________
or
Pharmacist Signature: ____________________________________ Date: ____________________
Pharmacist Address: ____________________________________ Phone: ____________________

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If you have any questions about this form call: ___________________________ (Principal) at___________________________

Form ADMIN 330-03 Administration of Medication Monthly Log

<table>
<tr><td colspan="3">Reminder: Administration Checklist (on log)

1. Compare the information recorded on the request for administration with the pharmacy label on the medication container.
2. Check the expiry date on the medication.
3. Confirm student's surname and first name.
4. Record each occasion when medication is given.
5. Record dates when student is absent</td><td colspan="3">AFFIX CURRENT PHOTO OF STUDENT HERE</td></tr>
<tr><td colspan="6">MOOSONEE DISTRICT SCHOOL AREA BOARD
STAFF ADMINISTRATION OF MEDICATION MONTHLY LOG
(Administrative Procedure 330)</td></tr>
<tr><td colspan="6">NAME OF STUDENT ____________________________DATE OF BIRTH _______________</td></tr>
<tr><th>Date</th><th>Time</th><th>Medication</th><th>Dosage</th><th>Signature of Person Administering</th><th>Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Form ADMIN 330-04 Person Responsible for Procedure

PERSON RESPONSIBLE FOR PROCEDURE

I have agreed to be responsible for the administration of medication(s) and/or medical procedures

____[Please describe]

as requested by ____
(parent/guardian)

The administration will occur in **Moosonee Public School.** The medication(s) and/or medical

procedures have been indicated by the physician _____________________________________

I agree to maintain a log of the administration of this medication and/or medical procedure. I understand that I am performing this procedure under the principle of "in loco parentis" and not as a health professional.

_________________________ ____
Date Signature

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