Appendix B
Page 1

REQUEST FOR SCHOOL ASSISTANCE IN HEALTH CARE

STUDENT INFORMATION

_____ **D.O.B.:** _____ **Current Age:** _____
Surname **Given Name** year/month/day

_____ **Telephone:** _____ **School:** _____
Address (Street/Town/Postal Code)

_____ **Grade:** _____ **Principal:** _____

TYPE OF HEALTH CARE ASSISTANCE

Administration of Medication: ☐ Prescription
☐ Supervision of student's self-administration of medication

Type **Schedule**

☐ Oral ☐ Injected (Epi-pen, Epi-pen Jr.) ☐ Short-term ☐ On-going
☐ Inhaled ☐ Other (specify) _____ ☐ Emergency
☐ External (specify) _____ ☐ Trial ☐ 2nd Treatment available
☐ Asthma Inhaler (specify) _____ (see licenced medical practitioner's statement)

Expiry date for medication, if applicable: _____

Is refrigeration for medication required? ☐ Yes ☐ No

NOTE: Expiry date is of particular importance for emergency use which is stored for long periods (i.e. Epi-pen®).

Reason for taking medication: _____

Child wears MedicAlert™ ☐ Bracelet ☐ Necklace

LICENCED MEDICAL PRACTITIONER'S STATEMENT FOR HEALTH CARE ASSISTANCE DURING SCHOOL HOURS

In my opinion, the following procedures are medically appropriate for the above-named student and should be administered during school hours.

1. Name of procedure(s) or medication(s): _____
2. Administration during school day: ☐ _____ a.m. ☐ _____ p.m.
3. Administration/procedure required for: ☐ _____ days ☐ remainder of school year
   ☐ emergency only ☐ 2nd treatment recommended if medical help unavailable within _____ minutes

Name of Licenced Medical Practitioner: _____ Telephone: _____

Signature of Licenced Medical Practitioner: _____ Date: _____

Appendix B
Page 2

PARENT/GUARDIAN APPROVAL
I hereby authorize and request the administration of the above medication(s)/procedure(s) for the above-named child in the manner and duration stated by the licenced medical practitioner. I will provide the medication to the school in a container clearly labelled by the pharmacist and give any necessary instruction as to the storage of same medication.

Parent/Guardian Signature: _____ Date: _____

1. ***A new authorization form must be submitted each school year and whenever the medication(s)/procedure(s) are modified. This form must be retained in the school for one year after termination of medication/procedure.***
2. ***It is understood that the staff person is administering medication or providing service under the principle of "in loco parentis" and not as a health professional.***
3. ***In the event that a "licenced medical practitioner's statement" does not accompany the Request for School Assistance in Health Care form, the St. Clair Catholic District School Board assumes no responsibility for the administration of medication or the self-administration of medication by students. Principals are to advise a parent requesting school assistance in health care without a licenced medical practitioner's statement of this in writing.***

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NOTICE

Authorization for the collection and maintenance of the personal information recorded on this form is the Education Act, R.S.O. 1980, S.265 (d) and S.266 and the Municipal Freedom of Information and Protection of Privacy Act. Users of this information are Supervisory Officers, Principals and teachers at the school. Any questions regarding the collection of personal information should be directed to the Principal of the school.

I/We hereby consent to the use of personal information contained herein by the persons above-named and by such other officers or employees of the Board who may need the personal information in the performance of their duties as employees of the St. Clair Catholic District School Board.

Signature of Parent/Guardian: _____ Date: _____

By signing in the space below I agree that the school may post my child's picture and display pertinent information to the staff of the school and health care providers.

Signature of Parent/Guardian: _____ Date: _____

FOR SCHOOL OFFICE USE
Medical Intervention Plan necessary: ☐ Yes ☐ No
If yes, attach a copy of the completed plan.
NOTE: **Medical Intervention Plan must be completed for anaphylactic shock and may be necessary for diabetes or epilepsy.**

SUPERVISION: Person(s) designated to supervise/administer medication(s)/procedure(s) and to maintain record:

Name: _____ Alternate: _____
(Signature) (Signature)

Principal's Signature: _____ Date: _____

Distribution: O.S.R.
School Office