Appendix:
Appendix 1

THE DURHAM DISTRICT SCHOOL BOARD

Request for Administration of Oral Medication

You have requested to have prescribed oral medication administered to your child by school personnel during school hours. The Durham District School Board believes that the administration of medication to students is the responsibility of the student's parent(s) or guardian(s). However, the school will endeavour to assist in the administration of oral prescription medication on the following terms and conditions:

The oral medication is prescribed by a physician, is essential for the student to continue to attend school on a long-term basis; must be administered during the school day or during school-sponsored events, it is not possible for the student to self-administer it, and the parent or guardian is unable to make other arrangements for someone to administer it as necessary;
The attached form must be carefully and fully completed by you and your physician prior to the start of each school year or prior to the commencement of the administration of that oral medication in the school year. If the form is not complete and legible, the school staff may be unable to safely administer the oral medication and your request for administration by school personnel may be denied. Therefore, please ensure that the instructions from the physician are very clearly stated, including the drug name, dosage, and frequency, or any other aspect of administration if changed during the school year. It is the parental responsibility to ensure that school staff have up-to-date information at all times, including current emergency contact information so that someone can be reached by the school at all times**;**
You are required to provide the school with all information needed for school field trips, and you are encouraged to require your child to wear a medical information/alert bracelet or pendant at all times while at school or engaged in school-related activities;
The oral medication must be delivered to the school in the original tamperproof prescription container, clearly labelled with the child's name, the name of the medication, the dosage and frequency, the physician's name, storage and safe-keeping requirements, and the expiry date of the oral medication [it must not be at or near expiry]. The medication must be accompanied by a drug insert listing the possible side effects. If the drug expires or the supply runs out, the dosage will be missed unless you as the responsible parent or guardian have made arrangements for a further supply to be delivered to the school.
You must agree, by signature below, that the Durham District School Board (the "Board"), its employees and agents, including school administration, staff and volunteers, will not be held responsible for any illness or injury to your child relating to or resulting from the administration of the medication. You will assume all responsibility in this regard. You are aware that the school does not have health care professionals to administer the medication, and school staff are not medically trained for this purpose.
The school and school staff are agreeing only to assist you in the administration of the prescribed oral medication. This agreement does not in any way change or relieve you of your parental responsibilities, and it and all accompanying paperwork will expire at the end of this school year. In order to have medication administration re-commenced in the next school year, you are responsible to submit a new and fully completed Request for Administration of Oral Prescription Medication.

I/We acknowledge receipt of this letter, have reviewed its contents, and agree to accept all terms and conditions as set out, in return for the school/school staff's assistance to administer oral prescriptive medication to my/our child, based on the information provided on the "Medication and Administration Information" Form.

I/We hereby request that the medication, as set out in the attached Medical and Administration Information Form, be administered orally to our child in accordance with the included physician's instructions.
I/We understand that the Durham District School Board and its employees will not be legally responsible for the administration of the medication.

_____ _____
Signature of Parent #1 Date of Signature

_____ _____
Signature of Parent #2 Date of Signature

Appendix 2

MEDICATION AND ADMINISTRATION INFORMATION

Student Name: _____ Home Telephone No.:_____

Address:_____

Date of Birth: _____ School: William Dunbar P.S Grade: _____

Parent/Guardian Name: _____Business Phone_____

Other Contact Name & Phone # _____

Physician's Instructions for Administering Oral Medication [to be completed by the Physician]

_____

Name of Medication: _____ Dosage [print] _____

Frequency and Method of Administration:

_____

Dates for which authorization applies (length of time medication is to be given):

_____

Possible side effects (please include or attach a drug information insert if available):

_____

Storage & Safekeeping requirements (medication is normally stored in a locked, non-refrigerated cabinet or area).

_____

Physician's Name and Address (Print) _____

_____

Physician's Phone # _____ Physician's Signature _____

NOTE: **This request will expire June 30 of each year.**

Appendix 3

THE DURHAM DISTRICT SCHOOL BOARD
ADMINISTRATION OF ORAL MEDICATION

CHILD MEDICATION LOG

Name of child/pupil: _____
Name of Parent: _____
Home Address: _____
Home Phone: _____ Business Phone: _____
Name of Prescribing Physician: _____
Office Address and Phone: _____

DATE	***NAME/DOSE OF MEDICATION***	***TIME GIVEN***	***STAFF SIGNATURE***	***COMMENT/ OBSERVATION OR REACTION IF SIGNIFICANT***