



POLICY NO. 5140

**MEDICAL ALERT AND ADMINISTERING
MEDICATION TO STUDENTS**

POLICY

Schools must maintain up-to-date information on any student who has a medical condition that may require emergency care at school.

Students who are on medication which they have to take during school hours should be treated with the utmost care. In order to avoid any confusion over what is or is not required, the following regulations for the administration of medication should be **STRICTLY** adhered to.



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**MEDICAL ALERT AND ADMINISTERING
MEDICATION TO STUDENTS**

REGULATIONS

1. Schools will ensure that they implement a system to obtain current information on any student who has a medical condition that may require emergency care at school. The "Medical Alert System" form will be used.
 - 1.1 Such information will be updated annually.
2. The Medical Alert System should ensure that staff are aware of the student's condition and are familiar with the appropriate action to take if required.
3. If it is required that a student take medication during school hours the school should ensure that the "Request for Administration of Medication at School" form has been completed.
4. Teachers shall not be called on to administer medication on a regular or predictable basis. Exceptional circumstances will be discussed with the Association.
5. In an emergency situation, an employee of the Board is expected to act as a responsible parent might in the administration of medication in any form to a child.

MEDICAL ALERT SYSTEM

Student Name: _____ Date of Birth: _____
Y / M / D

Personal Health Care No. _____
(from Care Card)

Parents' Names: _____

Telephone: Home: _____ Mother's Work: _____ Father's Work: _____

Other Name and Phone Number: _____

Name of Physician: _____ Physician's Phone: _____

Indicate what medical condition this student has that may require emergency care at school:

Describe the potential problem (include symptoms that might be observed):

Continued on reverse . . .

THIS FORM MUST BE COMPLETED AT THE START OF EACH SCHOOL YEAR

Please check the signature / date at the end of this form to ensure it is current

Destroy all outdated forms

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

A. To be completed by parent or guardian.

Name	Birth Date (Y/M/D)
Parent or Guardian	Home Phone Business Phone
Physician	Phone

B. To be completed by prescribing physician LIST CONDITION(S) WHICH MAKE MEDICATION NECESSARY

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE

Additional Comments (possible reactions, consequences of missing medication, etc.)

Physician's Signature / Date

C. To be completed by parent/guardian

I request the school give medication as prescribed in the upper section of this form to my child whose name is recorded below.

Name of Child

I will notify the school promptly of any changes in medications ordered.

Date

Signature of Parent/Guardian

Continued on reverse. . .

D. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this card then date and sign below.

Date	Signature	Comments