Administering Medication
or Medical Treatment to Students

AF 316-A
12/2019

MEDICAL FORM TO BE UPDATED EVERY SCHOOL YEAR,
EVEN IF THERE ARE NO CHANGES

The information requested on this form is being collected pursuant to the School Act, notably Section 23 and the Freedom of Information and Protection of Privacy (FOIP) Act. Information acquired through this form is kept secure and access to the information is restricted. Cross reference to Administrative Procedure 316, particularly Procedure 2.2

STUDENT IDENTIFICATION INFORMATION		**Administrative Procedure 316**
School:		
Name:	Date of Birth:	
AB ED. ID#:	Gender:	Grade:
Address:	Home Phone:	
Parent/Guardian:	Work:	Cell:
Parent/Guardian:	Work:	Cell:
Physician:	Ph:	
Emergency:	Ph:	Relation:

MEDICATION / TREATMENT INFORMATION	Example: Allergies, medical conditions	
Medication(s)/Treatment prescribed:		
Purpose of Medication/Treatment:		
Term of Administration:	From:	To:

SEVERE ALLERGY - a severe allergy is defined as a severe allergic reaction or anaphylactic response which, if left unattended can lead to sudden death.

Severe Allergen(s):	Symptoms:

Medical Alert Bracelet/identification is worn: ☐ Yes ☐ No Bus route notified: ☐ Yes ☐ No ☐ n/a

Precautions (possible side effects of medication(s)/treatment and remedial action for side effects:

Special storage instructions and safekeeping requirements:

Will it be detrimental to the student's health if a single dose/treatment is omitted? ☐Yes ☐ No

Is the student able to self-administer his/her own medication/treatment? ☐ Yes ☐ No If Yes, please provide details:

List any important guidelines affecting health and safety that should be followed by your child during school hours (eg. activity restrictions)

CONFIRM IN WRITING AND SIGNED BY PHYSICIAN MEDICAL EMERGENCY PLAN:

Describe any medication(s) or medical procedure(s) that may be necessary in an emergency (see attached sheet)

THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE. (Signatures also required on Page 2.)

	Name	Signature	Date
Physician/Pharmacist/ Reg. Professional Signature			
Parent/Guardian:			

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This form, page 2 is required to be updated to track medication and treatment administered to the student for the term determined on page 1. Please continue to print, complete and attach as many Student Medication or Treatment to Students Administration Records as needed.

STUDENT IDENTIFICATION INFORMATION			**Administrative Procedure 316**
School:			
Legal Name:		Date of Birth:	Grade:

MEDICATION / TREATMENT SCHEDULE

Day	Time(s)	Medication Dosage/Treatment	Comments
Mon			
Tues			
Wed			
Thur			
Fri			
Sat*			
Sun*			

** For use only during extra and co-curricular activities.*

ADMINISTRATION RECORD *(School Use Only)*

Date	Time	Medication Dosage/Treatment	Provided/Monitored by	Comments

Physician/Pharmacist/Reg. Professional Signature: Date:

Parent/Guardian Signature: Date:

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STUDENT IDENTIFICATION INFORMATION		**Administrative Procedure 316**
School:		
Legal Name:	Date of Birth:	Grade:
Parent:/Guardian	Work:	Cell:
Parent/Guardian:	Work:	Cell:

CONSENT:

The undersigned_____, being the legal parent(s)/guardian(s) of_____, a student of_____request and authorize by way of this document an employee or agent of the School Board to administer medication/treatment to the above-named student, and for so doing, this request and authorization will serve as a release of and indemnification from, any action, causes of action, or any suit commenced in law, equity, or by way of statue by the undersigned against the school board, its trustees, employees and agents arising from any action or inaction of any of the above-mentioned persons in context of administering medication/treatment to the above named student. Further, the undersigned parent(s)/legal guardian(s) recognize and acknowledge that the employee or agent of the School Board, who may, as a result of this request, be administering the medication/treatment to the above-named student, is not a medical practitioner. Finally, the undersigned parent(s)/guardian(s) recognize and acknowledge that the above is subject to the attached conditions set forth in this document, which have been read and understood.

Dated at_____, in the Province of Alberta,

this_____day of_____, A.D 20_____.

This Authorization for Administration of Student Medication/Treatment Release form is subject to:

1. The parent/legal guardian providing the medication/treatment prescribed by the student's physician and specific instructions pertaining to the administration of that medication/treatment (see Physician's information).
2. The parent/legal guardian repeating and updating this instruction if:
   (a) the student's medical condition changes; and/or
   (b) the medication/treatment requirements change.
3. The parent/legal guardian understanding that, should a medical emergency arise, the employees or agents of the School Board are to summon medical practitioners or paramedics for assistance and that the parent/legal guardian is financially responsible for such emergency medical assistance.
4. This form is valid only for the school year in which it is submitted.

I hereby declare that I have read and understood the information contained on this form and the "Use of Personal Information", and that the information I have provided is correct.

Parent/Guardian Signature:_____**Date:**_____

If you have any questions regarding this request for information and / or the use of, please contact the Associate Superintendent of Learning or the Director of Learning Supports.

Trained Staff in above-named student's medication or medical treatment administration:		
1.	2.	3.

Person responsible for teaching school staff:

☐ Parent(s)/Guardian(s)_____

☐ Other (please specify)_____

Reference:

AP 316 Administering Medication or Medical Treatment to Students