FORM 1

Toronto Catholic District School Board

REQUEST AND CONSENT FOR THE ADMINISTRATION OF ORAL MEDICATION

Student Name ______________________ ______________________ Student No.____________________

SURNAME FIRSTNAME

Birthdate ______________ Grade/Placement ______ School ______________________________

YYYY/MM/DD

SCHOOL ADDRESS ____

____

I/WE, THE PARENT(S)/GUARDIAN REQUEST AND CONSENT FOR THE ADMINISTRATION OF ORAL MEDICATION.

Home Tel. ________________ Home Tel. ________________

I/We ________________________ Bus. Tel. ________________ Bus. Tel. ________________

request that the TCDSB provide for the administration of medication for my /our son/daughter.

I/We understand that:

a) a medical doctor must consent to this request in accordance with Section 2 of this form.

b) only a limited supply of the medication may be kept at the school as prescribed by the doctor;

c) the medication must be brought to the school in a closed container and the label must detail the name of the student, the type/name of the medication, and the size of the dosage;

d) if the medication is not provided to the school, contact will be made with the parent(s)/guardian or doctor, and will also be made with parent(s)/guardian or doctor under any other exceptional circumstances, e.g. pupil refuses medication;

e) it is the responsibility of the school to establish fall back positions for the administration of oral medication.

I/We consent to:

a) the establishment of a service at the school to administer prescribed medication to my/our son/daughter named above;

b) school personnel responsible for the administration of medication discussing any aspect of the service with a public health nurse where the need arises.

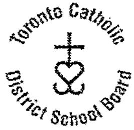
________________ ________________________ ________________________

Date Y-M-D Signature of Parent/Guardian Signature of Parent/Guardian

Please have the family doctor complete Part 2 on reverse side of this form.

Distribution: Original: OSR Copy: Parent(s)/Guardian, Special Program Files(s)

FORM 1 (Cont)



Toronto Catholic District School Board

REQUEST AND CONSENT FOR THE ADMINISTRATION OF ORAL MEDICATION

Student Name ______________ ______________ Student No. ______________
SURNAME FIRSTNAME

II. DOCTOR'S APPROVAL FOR THE ADMINISTRATION OF ORAL MEDICATION IN THE SCHOOL

1. Diagnosis:

2.

Medication Prescribed	Dosage	Time of Administration			Amount to be Maintained at School
		Mid - AM	Noon	Mid - PM	
a)					
b)					

3. The parent(s)/guardian of the above named pupil have requested the Toronto Catholic District School Board to offer a service for the administration of medication to their child in the school. The Board requires a doctor's approval before implementing such a program. Your signature below will provide required approval with the following specific directions (if any, e.g. refrigeration, reactions):

I approve the administration of oral medication as described above for:

Student's Name

Doctor's Signature

Date: Y-M-D

PLEASE USE DOCTOR'S STAMP

III. TCDSB STAFF APPROVAL FOR IMPLEMENTION

The administration of oral medication service will be implemented as of:

Date Y-M-D | Principal's Signature | Signature of Parent/Guardian

Personal information contained on this form is collected under the authority of Sections 8 and 11 of the Education Act, and will be used as an authorization for prescribed medication. Questions about this collection should be directed to the above doctor through the parent(s)/guardian.

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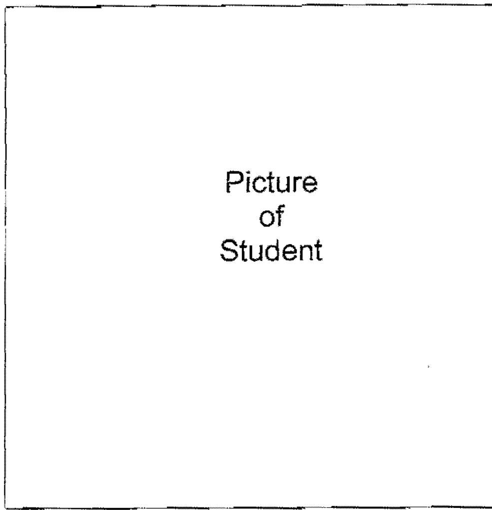
FORM 2

Toronto Catholic District School Board

School Based Student Support Services

EMERGENCY ALLERGY FORM

EPI-PEN ONLY



Name: ______________________

Address:

____

Home Phone: ______________________

Emergency Phone ______________________

Parent/Guardian Work Phone: ______________________

Parent/Guardian Work Phone: ______________________

Teacher: ______________________

Class: ____________ Room # ____________

Health Card #: ______________________

Physician ______________________

Physician's Telephone ______________________

Allergy-Description: This child has a **DANGEROUS,** life threatening allergy to the following items and to all foods containing them in any form in any amount:

Avoidance: The key to preventing an emergency is **Absolute Avoidance** of those foods at all times

Without An EPI-PEN This Child Must Not Be Allowed to EAT Anything.

Eating Rules: *(list eating rules for child, if any, in this space)*

Possible Symptions:

- ☐ Flushed face, hives, swelling or itchy lips, tongue, eyes
- ☐ Difficulty breathing or swallowing, wheezing, coughing, choking pains
- ☐ Dizziness, unsteadiness, sudden fatigue, rapid heartbeat
- ☐ tightness in throat, mouth, chest
- ☐ Vomiting, nausea, diarrhea, stomach pain
- ☐ Loss of consciousness

Action - Emergency Plan: At any sign of difficulty(e.g. hives, swelling, difficulting breathing);

- ☐ Use EPI-PEN immediately
- ☐ Have Someone Call An Ambulance to advise the dispatcher that the child is having an anaphylactic reaction.
- ☐ If ambulance has not arrived in 15-20 minutes and symptoms reappear or become worse, give a second EPI-P
- ☐ Even if symptoms subside entirely, this child must be taken to a hospital immediately.

EPI-PENS are kept in ____________ *Classroom/lunchroom/staff room/office/with student*

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