Grande Prairie Public School Division
10127 120 Avenue, Grande Prairie, AB T8V 8H8
Phone: 780-532-4491 Fax: 780-539-4265

Administration of Medication or Medical Treatment with Medical Training Form Duty of Care

This form is to be completed if a student's ***attendance at school requires that medication or medical treatment be administered at the school requiring a medically trained Licensed Practical Nurse (LPN).*** Completion of this form and authorization by the school principal is required in all instances. This form must be completed when a student registers at a school and permission, if granted, may not be transferrable from one school to another. This completed form must be obtained annually, or sooner if the student's condition changes as long as the student is in continuous registration at the school where this permission has been granted.

Student information is to be completed by the Parent/Guardian.
Medical Treatment Requirements and Medication Requirements – information can be completed by the parent/guardian or Physician but does **require a Physician's signature** for medical treatment or medication administration requirements.

STUDENT INFORMATION (to be completed by Parent/Legal Guardian or Independent Student)

Student Number	**Date**	
School Attending	**Birthdate** DD/MM/YYYY	
Student's Legal Last Name	**Student's Legal First Name**	**Student's Legal Middle Name**
Parent/Legal Guardian Name	**Phone Number**	**Cellphone Number**

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MEDICAL TREATMENT REQUIREMENTS (Information to be completed by parent/guardian or physician, and then signed by the Physician for medical treatment that can be administered by medically trained LPN staff.

A Physician's endorsement is required for administering medical treatment.

Medical condition(s) which necessitates the need of medical treatment by medically trained LPN staff at school: _____ _____ _____
Description of **Medical Treatment**(s) procedure including any specialized equipment, training required, authorized sources of training and appropriate emergency response which necessitates the administration of medical treatment at school by a medically trained LPN staff: _____ _____ _____ _____ _____ _____ _____

PHYSICIAN'S ENDORSEMENT FOR MEDICAL TREATMENT

The preceding information provided by the parent/legal guardian or Independent Student is correct: ☐ Yes ☐ No The assistance required of staff is within the competence of a person who is a medically trained LPN: ☐ Yes ☐ No	
Physician's Name (please print)	**Physician's Phone Number**
Physician's Location and Address	
Signature of Physician	**Date**

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MEDICATION REQUIREMENTS (Information to be completed by parent/guardian or physician, and then signed by the Physician for severe allergies or medical conditions requiring prescription medication.)

A Physician's endorsement is required for administering prescription medication.

Medical condition(s) which necessitates the administration of medication or medical treatment at school:

_____

_____

_____

Please fill out the medication names and details for administering them:

NAME OF MEDICATION	DOSAGE (HOW MANY? MUCH?)	FREQUENCY (HOW OFTEN?)	TIME OF ADMINISTRATION?

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS FOR EACH MEDICATION, IF APPLICABLE:

Medication storage requirements:

_____

Does the student require assistance in administering medication?: ☐ Yes ☐ No

If the student requires assistance, please explain the nature of assistance:

_____

_____

Possible side effects requiring emergency action:

_____

_____

Action necessary if an emergency arises:

_____

_____

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Additional instructions or information:

_____

_____

PHYSICIAN'S ENDORSEMENT FOR ADMINISTERING PRESCRIPTION MEDICATION

The preceding information provided by the parent/legal guardian or Independent Student is correct: ☐ Yes ☐ No The assistance required of staff is within the competence of a person who is a medically trained LPN: ☐ Yes ☐ No	
Physician's Name (please print)	**Physician's Phone Number**
Physician's Location and Address	
Signature of Physician	**Date**

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AUTHORIZATION REQUEST, CONSENT AND WAIVER

I hereby request that the above identified student be assisted with the administration of medication or medical treatment on the basis as set out above.

If my request is accepted, I acknowledge and agree that:

1. The above medical information is accurate, complete, and has been endorsed by the above-named physician.
2. Primary responsibility for the administration of medication and medical treatment rests with the student and myself, the student's parent/legal guardians;
3. Any change in the student's medical condition or medication(s) affecting this administration of medication or medical treatment request will be brought to the attention of the Principal promptly;
4. The Division has on staff a Licensed Practical Nurse that is medically trained with respect to breathing devices that assist division students with their breathing. They will rely upon the medical direction from the consulting physician and Alberta Health medical personnel, the manufactures guidelines for the devices and parental information provided by the parent/legal guardians to support the needs of the student;
5. Approval of this request is valid for one (1) year, for the school and school year in which the administration of medication or medical treatment is requested, and action taken by staff will be limited to what is described in this form and what is possible in a school setting.

I acknowledge that I have read and understood why I have been asked to complete this form. I am aware of the risks or benefits of consenting or refusing to consent to the administration of medication or medical treatment to my child. In signing this form, the parent/legal guardian or independent student releases the Grande Prairie Public School Division, its servants, employees and agents from and against all claims, suits, demands, and actions whatsoever taken now or in the future which may arise by reason of the administration of medication or medical treatment to the student. The action taken by staff as requested above is both requested and authorized. Staff are authorized to take emergency action when deemed appropriate.

Name of Parent/Guardian or Independent Student (please print)	
Signature or Parent/Guardian or Independent Student	**Date**

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PRINCIPAL'S APPROVAL

School	**Date**
Name of Principal	**Signature of Principal**

Personal information is collected under the authority of Alberta's Freedom of Information and Protection of Privacy (FOIP) Act and the Education Act. This information will be used to respond to potential emergency situations and/or to assist with medication application needs involving the students whom you have identified above. It will be treated in accordance with the privacy protection provisions of the FOIP Act. If you have any questions about the collection and/or its intended use, please contact the Principal, or the Division's FOIP Coordinator at 780-532-4491.