WESTMOUNT CHARTER SCHOOL
ADMINISTRATION OF PRESCRIPTION MEDICATION
AND/OR MEDICAL TREATMENT FORM

Student Information

Student's Name:		Grade/Class:	
Student's Alberta Health Care Number:		Student's Date of Birth:	
Home Address:			

Contact Information

Mother's Name:		Father's Name:	
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	
Cell Phone:		Cell Phone:	
Emergency Contact Name:		Phone:	
Physician's Name:		Phone:	

Students with Pre-Existing Conditions

If your child has a known, pre-existing health issue that causes COVID-19-like symptoms, they must be tested at least once according to the Alberta Health Services Guidance. This will establish a baseline for the student. *Please forward test results to the EC or MH campus office.* ***If you sign up for a MyHealthRecords Account, you should be able to access your test results in a timely manner.*** *https://myhealth.alberta.ca/MyHealthRecords* **A doctor's signature is required at the bottom of this form to verify condition(s).**

Description of pre-existing, COVID-19-like symptoms:

Severe Allergy Alert Information

This portion of the form should be completed only if the student has a severe allergy. A severe allergy is defined as a severe allergic reaction or anaphylactic response which, if left untreated, can lead to sudden death. **A doctor's signature is required if this section is filled out.**

Allergen(s):

Symptoms of a reaction:

Emergency Action Plan: *(attach separate sheet if needed)*

Medication/Treatment Information

A doctor's signature is required if your child has prescribed medication being left at the school

Medication prescribed:

Purpose of medication:
Medication dosage, time of administration and procedure for administration:
Medication storage and safekeeping requirements:
Specifics of treatment required, if any:
Possible side effects of medication(s)/treatment and remedial action for side effects:

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

Must this student have this medication/treatment administered during school hours in order to be able to attend school? Yes No

Self-Administration Information

Is the student able to administer his/her own medication/treatment? Yes No

If yes, provide details:

Charter Board policy requires that, except in emergencies, the student shall self-administer under adult supervision.

Informed Parental Consent and Acknowledgement

I am the parent of the student named above ("my child") and I acknowledge and agree:

1. I will provide an adequate and fresh supply of medication for my child.
2. I understand the medication will be stored in a secure location and administered by school staff unless I have given consent for my child to self-administer the medication.
3. I understand it is my responsibility to advise school staff of any change in my child's medical condition or medication.
4. I acknowledge that actions taken by school personnel will be limited to what is possible in a school setting, and to what can be done by persons untrained in medical procedures.
5. If any emergency arises, I authorize school personnel to administer medication and/or secure medical advice and services, including calling paramedics as deemed necessary. I agree to be financially responsible for such emergency medical assistance.
6. By signing this form, I consent to and authorize school personnel to administer medication/medical treatment to my child.
7. I understand that the Charter Board fully accepts responsibility for students under its care, and is liable to the parents and the students for any loss, injury or damages which occur as a result of the negligence of the school. I am fully aware that there are risks and hazards associated with the administration of medication or medical treatment and that my child may suffer bodily injury as a result of these risks and hazards, and my child may suffer personal and potentially serious injury due to an unforeseeable or fortuitous event.
8. This form is valid only for the school year in which it is submitted.

Date: _____________ Name of Parent: ______________________ Signature: _________________________

Physician's Endorsement

1. The information provided on this form is accurate and complete.
2. The assistance of school personnel required to administer this medication and/or medical treatment is within t competence of persons untrained in medical procedures.

Date: ____________ Name of Physician: __________________________ Signature: ____________________