

Frontier School Division acknowledges that some students may require prescribed medication during the school day. The Division realizes that the administration of the medication by the parent(s)/or legal guardian(s) of the child is not always possible at the required time during the school day. The Division also realizes that there are students who require prescribed medication and who, because of age, maturity level, or physical or cognitive ability, are unable to manage their own medication. In such circumstances, the Division will attend to the administration of prescribed medication provided that the parent(s)/or legal guardian(s) of the student meet all prerequisites as identified in the following regulations. It is expected that students are responsible for their own medication as soon as they are capable of accepting this responsibility.

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1. Responsibilities of Parent(s)/Legal Guardian(s)

Parent(s)/legal guardian(s) shall:

- a. provide the school annually, or upon change of medication, with a completed "Administration of Prescribed Medication to Students – Authorization Form" (Exhibit G.1.L- EX1) that includes:
 - a copy of the prescription and recommended dosage,
 - the physician's requirements specifying frequency and method of administration,
 - the physician's description of anticipated/possible reactions of the child to the prescribed medication,
 - the physician's signature,
 - parent(s)/legal guardian(s) permission and signature approving/authorizing the administration of the prescribed medication,
 - an outline of the method for delivering medication to the school Principal or Vice-Principal on request from the school authority,
- b. complete and sign the "Administration of Prescribed Medication to Students - Consent for Exchange of Information" form (Exhibit G.1.L-EX2),
- c. deliver safely the medication to the school Principal or Vice-Principal in its original container with label,
- d. notify the school Principal or Vice-Principal immediately if the medication is no longer required,
- e. ensure that the first dosage was administered at home/hospital and to confirm that the medication was well tolerated. This is the expected procedure; exceptions could be considered.

2. Responsibilities of the Principal or Vice-Principal

The Principal or Vice-Principal shall:

- a. ensure that there is an annual review of Administration of Prescribed Medication to Students policy, and that there is a copy of the "Administration of Prescribed Medication to Students – Authorization Form" (Exhibit G.1.L-EX1) form, which must be filed in the student's pupil file, and, accessible for immediate reference by the Principal, Vice-Principal or staff,
- b. Teachers shall not be required to administer medications or medical procedures of a non-emergency nature. In the unexpected absence of other school staff to administer medication, Principals and Vice-Principals may be required to administer medication, if they have received authorization from a student's parent(s)/legal guardian(s), and have completed training in administration of medication where required,

ADMINISTRATION OF PRESCRIBED MEDICATION TO STUDENTS

Regulation G.1.L-R

- c. ensure that the medication bottle carries the official label from the pharmacist stating the child’s name, physician’s name, name of the drug, the dosage to be administered and the time of day it is to be given,
- d. designate a specific area, with locked limited access storage space within the school to store the medication,
- e. administer the medication to the student as prescribed,
- f. maintains the “Administration of Prescribed Medication to Students - Record of Administered Prescribed Medication” (Exhibit G.1.L-EX3) and notes the date, time, absence or refusal and initials each entry,
- g. contact the parent(s)/legal guardian(s) immediately and, if they are not available, the alternate emergency contact person, if a student refuses to take the prescribed medication,
- h. only administer the prescribed medication to a child whose parent(s)/legal guardian(s) have completed the approved "Administration of Prescribed Medication to Students – Authorization Form” (Exhibit G.1.L-EX1) unless otherwise required in an emergency situation,
- i. return unused medication to the parent(s)/legal guardian(s),
- j. students residing at Frontier Collegiate require paperwork indicating administration during overnights and weekends,
- k. students who require medication administered at school may attend excursions or land based learning offsite with parent(s)/legal guardian(s) consent, and the Principal or Vice-Principal approval, alternate arrangements will be made to accommodate the administration of medication for the student,
- l. if students are away from school on a field trip, staff may call to request parent(s)/legal guardian(s) permission to provide over-the-counter medications as required (i.e. Tylenol),
- m. staff will follow and prioritize a student’s URIS plan in accordance with local nursing stations. If a student has a URIS plan, it will supersede this policy. Alternate arrangements to be made as necessary,
- n. Ensure that designated school staff receive appropriate training and certification in medication administration. This training should encompass First Aid, CPR, and handling allergic reactions.

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To be completed by Parent(s)/Legal Guardian(s)

STUDENT IDENTIFICATION:

Name _____
Date of Birth _____
M.H.S.C. # P.H.I.N. # _____

PARENT/GUARDIAN IDENTIFICATION:

Names _____
Work # _____
Work # _____
Phone _____
Address _____

SCHOOL IDENTIFICATION:

Name of School _____
Address _____
Phone _____

PHYSICIAN IDENTIFICATION:

Name _____
Address _____
Phone _____

Emergency contact if unable to reach parent(s)/legal guardian(s):

Name _____ Phone _____

TO BE COMPLETED BY PARENT(S)/LEGAL GUARDIAN(S) IN CONSULTATION WITH PHYSICIAN AND/OR PHARMACIST

MEDICATION INFORMATION: _____

Name of Physician Consulted _____ Phone _____

Name of Pharmacist Consulted _____ Phone _____

Name of Medication _____

Reason for Medication _____

Dosage and Method of Administration _____

Approximate time(s) of administration during the school day _____

Start Date : y/m/d _____ End Date : y/m/d _____

Specific storage requirements _____

Side effects to watch for and actions required if these side effects are observed _____

Action required if medication missed _____

ADMINISTRATION OF PRESCRIBED MEDICATION TO STUDENTS – AUTHORIZATION FORM

Exhibit G.1.L-EX1

- a) Parent(s)/legal guardian(s) must make every effort to ensure that medication does not need to be administered during school hours. The Division reserves the right to correspond with the physician/pharmacist should concerns about administration be presented by the staff.
- b) The parent(s)/legal guardian(s) is responsible for the delivery and supply of the medication. If requested, pharmacies will provide two original pharmacy labelled containers. Unused medication will be returned to the parent(s)/legal guardian(s).
- c) The medication container must carry the original label from the pharmacist stating the child's name, physician's name, name of the drug, the dosage to be administered and the time of day it is to be given. The container must also have the official label of the pharmacy.
- d) It is the responsibility of the parent(s)/legal guardian(s) to notify the school in writing of any changes in dosage or time of administration of medication.
- e) The Principal or Vice-Principal will administer the medication to the student as prescribed. If the designated staff member is unavailable and no other school staff are present, the Principal or Vice-Principal may administer the medication if they have received authorization and completed necessary training.
- f) The Principal or Vice-Principal shall refuse to administer prescribed medication to any child if parent(s)/legal guardian(s) have not fully completed this "Administration and Authorization of Prescribed Medication" form, except in emergency situations.
- g) The Principal or Vice-Principal will contact the parent(s)/legal guardian(s) immediately and, if they are not available, the alternate emergency contact person if a student will not take the prescribed medication.
- h) Authorization automatically terminates June 30th of the current school year or upon change in medication.

I hereby request and authorize the school to administer the prescribed medication to my child. I also certify that the first dosage of the medication was given at home/hospital and was well tolerated. The Principal or Vice-Principal is authorized to contact the physician/pharmacist regarding any questions as to the administration of the medication.

Parent(s)/Legal Guardian(s) Signature _____ Date _____

Principal or Vice-Principal Name _____ Signature _____

Date completed form received at the school _____

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ADMINISTRATION OF PRESCRIBED MEDICATION TO STUDENTS - CONSENT FOR EXCHANGE OF INFORMATION
Exhibit G.1.L-EX2

This form is required when requesting or sharing student-specific information with any individual or agency outside of Frontier School Division.

I, _____
(Print Parent(s)/Legal Guardian(s) Name)

consent for the exchange of verbal or written information between Frontier School Division and the individual/agency listed below regarding my child:

(Student's Full Name)

(Student's Birth Date: Day Month Year) MET #

who is attending _____ School.

I authorize the release of information as is reasonably necessary to support the above-named student's appropriate programming. I understand that this consent is valid for 1-year, and that I can make changes to this consent at any time.

This exchange of information with: _____
(Name of Agency)

(Name of Representative if known)

(Address)

I/We understand that the privacy provisions of *The Freedom of Information and Protection of Privacy Act* protect all information shared. Frontier School Division will keep this information in a confidential file, to be seen only by those people working on behalf of this child.

Signature of Student (if legal age) Date

Signature of Parent(s)/Legal Guardian(s) Date

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ADMINISTRATION OF PRESCRIBED MEDICATION TO STUDENTS - RECORD OF ADMINISTERED PRESCRIBED MEDICATION
 Exhibit G.1.L-EX3

School _____

Student Name _____

Birth date _____ (y / m / d)

Medication: _____

Dosage _____ Time to be administered _____

Doctor _____ Phone # _____

Pharmacist _____ Phone # _____

Date	Time Given	Staff Initials	Successful (S) Missed (M) Absent (A) Refused (R)	Comments

Notes:

1. This form is to be completed and initialed each time medication is administered.
2. A separate form is to be completed for each prescribed medication.

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