Tłı̨chǫ Community Services Agency
Do꞉ Nàke Lani Nàts'etso – Strong Like Two People

ADMINISTRATION OF PRESCRIBED MEDICATION PLAN

Administration of Prescribed Medication

The Tlıcho Communıty Servıce Agency (TCSA) acknowledges that certaın students may requıre prescrıbed medication during the school day. The TCSA School principal shall desıgnate an individual to admınıster prescribed medıcatıon provıded school staff assıstance ıs requıred ın admınısterıng the medıcatıon and only ıf a parent/guardian of the student completes (and arranges for completıon of) thıs plan. A parent or guardian shall complete a new form each school year and/or whenever the physıcıan changes or renews the prescrıption. The TCSA Health and Social Services staff may periodically review the plan in accordance with the policy.

PART A - STUDENT IDENTIFICATION AND CONTACT INFORMATION

To Be Completed by Parent/Guardian

Student Name (Last Name, First Name)	Date of Birth (dd/mm/yyyy)	Gender Preference	Family Members in same school
Address		Postal Code	Health Care #
Contact Numbers	Medical Alert Yes or No	Teachers	Classroom/Homeroom
Parent/Guardian 1		Home/Cell Phone Number	Work Number
Parent/Guardian 1		Home/Cell Phone Number	Work Number
Emergency Contact Person		Home/Cell Phone Number	Work Number

Personal information and personal health information is collected under the NWT *Education Act* and *Health Information Act* and will not be used or disclosed, unless allowed or required by these Acts or any other Act.

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PART B - PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

To Be Completed by Parent/Guardian

a) I request that the medication _____
name of medication

be administered to _____
name of student

for a time period of _____
from mm/dd/yy till mm/dd/yy

b) I will provide the medication to the school in the original container, with the original pharmacy label, and I will meet with the principal.

c) I shall notify the school immediately if the medication is no longer required.

d) OPTIONAL: Only complete if applicable

OPTIONAL: I advise of the following side effects of medication observed when administered to my child:

_____

_____ _____

Date (mm/dd/yy) Name of Parent or Guardian

_____

Signature of Parent or Guardian

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PART C - HEALTHCARE PROVIDER MEDICAL AUTHORISATION

To Be Completed by the Attending Physician

Re: _____

name of student and date of birth (mm/dd/yyyy)

a) Specify the medication, dosage, frequency and the method of administration of this medication during the school day:

_____

_____

_____

_____

b) I anticipate the child's reactions to the prescribed medication will be:

_____

_____

_____

_____

_____ _____

Date (mm/dd/yy) Name of Physician

_____ _____

Telephone Signature of Physician

_____

_____

Address

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ADMINISTRATION OF PRESCRIBED MEDICATION PLAN

PART D – TCSA INTERNAL RECORD AND DESIGNATION SHEET

To Be Completed By the TCSA Principal or Designate

Administrative Staff (Principal or Vice Principal) designated to supervise/administer medication	
Alternate/s (*Only the above staff is assigned to give medication - the alternate is a delegate should the P/VP be away from school)	
Location of Medication in the School	
Signature of Principal	Date (mm/dd/yyyy)

THIS FORM IS TO BE RETAINED BY THE SCHOOL