North Vancouver School District
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ADMINISTRATIVE SERVICES
Ph: 604.903.3444
Fax: 604.903.3445

Student Focused Medication Management
Parental Consent

Student Name (Last/First): ____________________

Date of Birth (d-m-y): ____________________

Grade: _____ Div./Homeroom: _____

Parent Name: ____________________ **Parent Name:** ____________________

Phone (Home): ____________________ Phone (Home): ____________________

Phone (Work): ____________________ Phone (Work): ____________________

Cellphone: ____________________ Cellphone: ____________________

Emergency Contact Name: ____________________

Phone (Home): ____________________

Phone (Work): ____________________

Cellphone: ____________________

Pharmacy Name: ____________________

Phone: ____________________

Physician Name: ____________________

Phone: ____________________

The information you provide will be held in confidence to assist school personnel in responding appropriately to the medication management needs of your child. All information placed in a students file will be protected and used in compliance with the Freedom of Information and Protection of Privacy Act (FIPPA) and the Health Information Act (HIA), where applicable.

I request that the school personnel administer/monitor my child's medication in accordance with **the Student Medication Management Plan.**

I will supply the physician prescribed medication in its original container with the pharmacy label attached. The dose schedule of medication has been planned such that a minimum number of doses will be given at school. Medication and refills will be supplied to the school when necessary.

Parent/Guardian Signature: ____________________ Date: ____________________

School Signature: ____________________ Date: ____________________