Issue Date	May 15, 2019
Revision Date	May 20, 2020
Review Year	2025

Objective:
To support implementation of Board Policy on the administration of medication to students.

Responsibility:
Employees

Regulation:

1. Information Required
   a. Any student suffering from a known medical condition, regardless of whether medication is prescribed shall have that condition identified and updated by the parent/legal guardian on the *Student Registration file* in *Family Zone.*
   b. Aurora School shall maintain a *Student Medical Information* binder in which records of the administration of medicine or other medical treatment shall be kept.
   c. Parent/legal guardian will complete the *Student Medication Management Plan* for every student suffering from a known medical condition or for each incident requiring medical intervention. The completed form shall be kept in the *Student Medical Information* binder in a readily accessible location in the school office that is known to all staff members. All records shall be retained for seven years.
   d. The Principal shall be responsible for informing all personnel having direct responsibility for each particular student's medical well-being.
   e. Parents shall be responsible for ensuring that the Principal is kept informed of any changes in the health or treatment protocol of the student.
   f. The above information is provided in accordance with the *Freedom of Information and Protection of Privacy Act.*

2. Administration of Prescription Medicine
   a. If a request is made to administer prescription medication at school to a student who is not developmentally able to self-administer the medication and medication cannot be administered outside school facility hours:
      i. If the Principal determines the request is reasonable, arrangements will be made with a staff member to administer the prescription medication in the appropriate setting.
      ii. The Principal shall ensure adherence to 1.b. and 1.c. above.
      iii. The parent/legal guardian shall be responsible for providing accurate relevant information regarding medication such as dosing, frequency, route of administration and side-effects by completing a *Student Medication Management Plan*.
      iv. The parent/legal guardian shall be responsible for providing sufficient physician prescribed medication in the original container/packaging that is clearly labeled and non-expired,
      v. If changes are made to medication or administration of medication, the parent shall provide a physician's note to the school indicating the changes and update the *Student Medication Management Plan* and the student information on *Family Zone*
      vi. The Principal shall be responsible for ensuring that all medication kept at school is stored appropriately and is accessible to staff who are involved with its administration.

2. Emergency Treatment with Prescription Medication
   a. In the event that a student has a potentially fatal or debilitating allergic reaction that requires immediate emergency treatment (e.g. anaphylaxis) or displays potentially serious symptoms of a known medical condition (e.g. epilepsy, insulin shock) for which prescription medication has been provided:
   b. The Principal or attending staff member shall administer the treatment or the medication in strict accordance with the physician's instructions or the *Student Medical Management Plan* or in accordance with the best available instructions at the scene.
   c. The student's parents shall be contacted as soon as possible and informed of the situation.
   d. A staff member will call "911" to secure trained medical assistance.

3. Medical Treatment for Other Illness or Accidental Injury
   a. In the event that a student suffers an accident or becomes otherwise ill while attending school:
      i. The attending staff member shall determine what first aid procedures are appropriate and apply those procedures as quickly as possible.
      ii. The student's parents will be contacted as soon as possible and informed of the situation.
      iii. A staff member shall supervise the student until the parent or trained medical personnel arrive and assume care.
      iv. If deemed necessary, a staff member shall call "911" to secure trained medical assistance.
      v. The attending staff member shall fill out an *Accident Report* form for each incident. The form shall be reviewed and signed by the Principal and then kept on file for seven years.

References:

Emergency Medical Aid Act, R.S.A. 2000 (Alberta's Good Samaritan legislation).
BP 6101 Administering Medication to Students - Alberta Health Services: Guidelines
The Education Act

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SUPPORTING FORMS AND DOCUMENTS USED BY SCHOOL ADMINISTRATION

Request for medication to be given at school (Aurora Elementary)

Date:
To: Parent or Guardian
RE: Request for Medication to be given at School

Each student should have their own ***Student Medication Management Plan (Form A, B & C)*** to ensure safe medication management at school. This plan will be developed in a meeting with the school principal and parent/guardian.

Before this meeting, please:

1. Consult with your child's physician and/or pharmacist to determine if medication(s) can be managed outside of school facility hours. If this is not possible, a meeting to develop a Student Medication Management Plan must be arranged with the school principal.
2. Ask the pharmacist for detailed information regarding medication such as dosing, frequency, possible side effects and method of administration.
3. Complete the parent section of the *Student Medication Management Plan Form B* (SMMP). Use the pharmacy label on your child' medication and the pharmacy information sheet.
4. Complete and sign the *Student Medication Management Parent Consent Form A*.
5. Return the completed forms to the Principal and arrange a time to meet about the SMMP with the principal.
6. Enter the medical condition and medication requirement on the student file in Family Zone and continue to update information as medical needs change. Also, provide a physician's note to the principal detailing any changes to medication, dosing and administration of medication.

____
School Principal

Student Medication Management Parent/Guardian Consent Form A

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Administration of Medication

Student Medication Management Parent/Guardian Consent

Student's Name: ___________________________________
(Last/First)

Date of Birth: _________________________
(Day/Month/Year)

PLEASE PRINT CLEARLY

Parent/Guardian Name: ________________________________
Phone (home) _________________ (work) ________________
Mobile Ph: _____________________________

Parent/Guardian Name: ________________________________
Phone (home) _________________ (work) ________________
Mobile Ph: _____________________________

Emergency Contact Name: ______________________________
Phone (home): __________________ (work): _______________
Mobile Ph: _____________________________

The information you provide will be kept confidential. All information provided will be protected and used in compliance with the Freedom of Information and Protection of Privacy (FOP) Act and the Health Information Act (HIA), as applicable

I request that school facility staff administer/monitor my child's medication as outlined in the **Student Medication Management Plan** for my child.

I will give the school the physician prescribed medication in its **original container** with the current **pharmacy label attached.**

The medication dose schedule 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

Signature of Parent/Guardian ___________________________________ Date: _________________________

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Student Medication Management Plan Form B

This plan is intended for physician prescribed medications only

Student's Name: ___________________________________
(Last/First)

Date of Birth: _________________________
(Day/Month/Year)

PLEASE PRINT CLEARLY. DO NOT USE ABBREVIATIONS. UPDATE ANNUALLY.

		Medication #1 ☐ Administer ☐ Monitor	**Medication #2** ☐ Administer ☐ Monitor	**Medication #3** ☐ Administer ☐ Monitor	**Medication #4** ☐ Administer ☐ Monitor
	Received medication in original container	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
COMPLETED BY PARENT	Medication Information sheets provided	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Name of medication				
	Therapeutic effect(s) of medication				
	Possible side effect(s) of medication				
	Plan of action for possible side effect(s)				
	Medication Dose				
	Route of administration (e.g. by mouth)				
	Time(s) medication to be given at school facility				
	Start date of medication				
	Finish or review date of medication				
COMPLETED DURING MEETING	Medication location for administration/monitoring				
	Name of staff person to administer/monitor medication				
	Name of alternative staff to administer/monitor medication				
	Special instructions (Please attach pharmacy information sheet)				

Parent Name: ___________________________ Signature: _________________________________ Date: ______________________

Staff: _________________________________ Signature: _________________________________ Date: ______________________

Other: ________________________________ Signature: _________________________________ Date: ______________________

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Student Medication Management Record Form C

Student Medication Management Record

Student's Name: ___________________________________
(Last/First)

Date of Birth: _______________________
(Day/Month/Year)

			Date: Month ____________________________ Year ________________																			
Medication	**Dose**	**Time**																				

Date	**Comments**	**Initials**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Administered/monitored by:

Print Name:	Signature:	Initials:
__________________________	______________________________	__________
Print Name:	Signature:	Initials:
__________________________	______________________________	__________
Print Name:	Signature:	Initials:
__________________________	______________________________	__________

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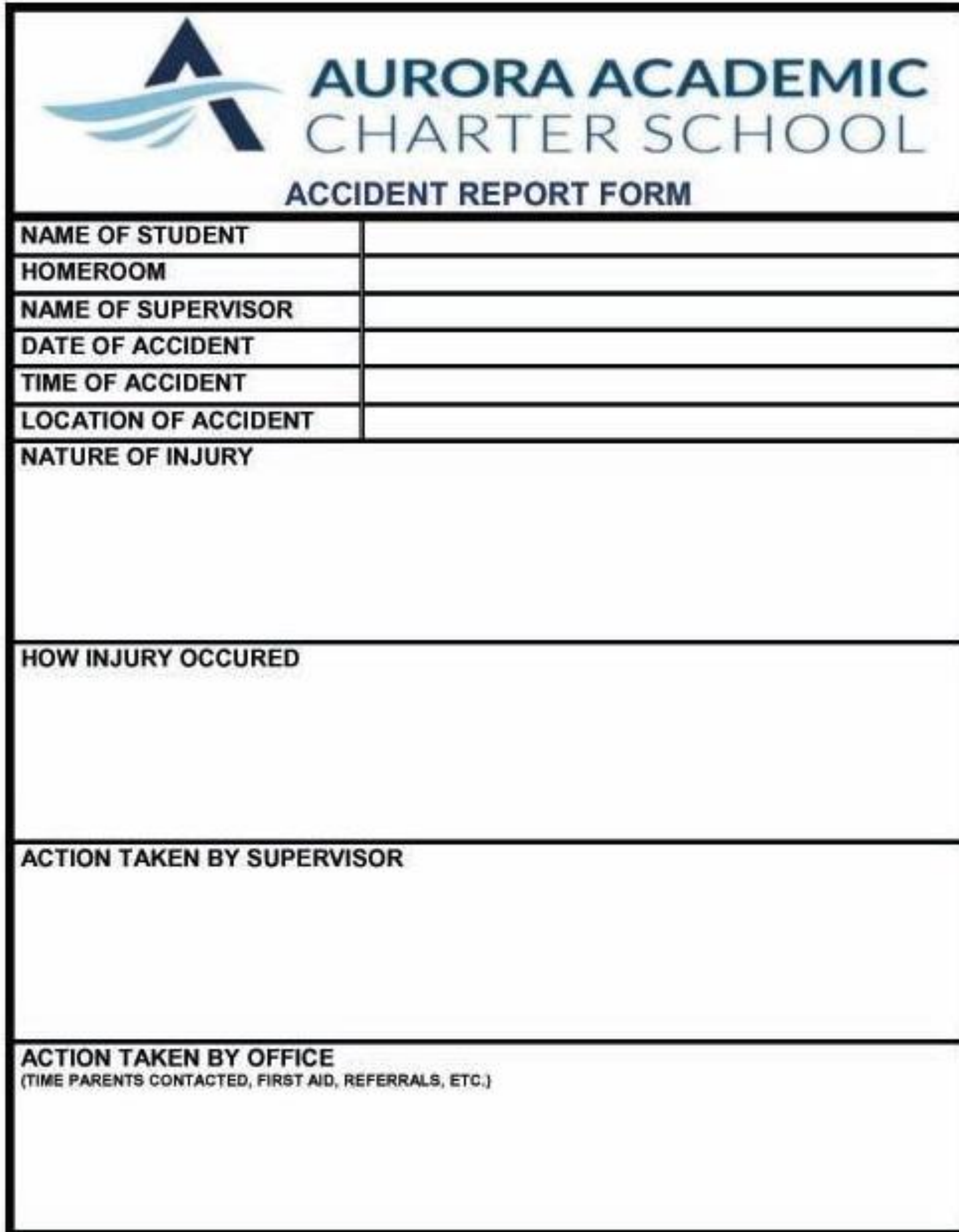

AURORA ACADEMIC CHARTER SCHOOL

ACCIDENT REPORT FORM

NAME OF STUDENT	
HOMEROOM	
NAME OF SUPERVISOR	
DATE OF ACCIDENT	
TIME OF ACCIDENT	
LOCATION OF ACCIDENT	

NATURE OF INJURY

HOW INJURY OCCURED

ACTION TAKEN BY SUPERVISOR

ACTION TAKEN BY OFFICE
(TIME PARENTS CONTACTED, FIRST AID, REFERRALS, ETC.)

SIGNED: ______________________ ______________________
(SUPERVISOR) (PRINCIPAL)

____
(OFFICE STAFF)

December 12, 2018

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