WEST VANCOUVER SCHOOLS

Student Focused Medication Management Plan

Parental Consent {Form 316-1)

Student Name {Last/First):	
Date of Birth (day/month/year)	
Gender:	**I Male** **I Female**

Additional information related to the reason for administration of medication (e.g. allergies, etc.)

Parent/Guardian Name:	**Parent/Guardian Name:**
Phone (Home):	**Phone (Home}:**
Parent (Work):	**Parent {Work):**
Pager/Cell:	**Pager/Cell:**

Emergency Contact Name:	**Pharmacy Name:**
Phone {Home):	**Phone:**
Parent (Work):	**Physician Name:**
Pager/Cell:	**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 student's file will be protected and used in compliance with the Freedom of Information and Protection of Privacy {FIPPA} Act and the Health Information Act {H!A}, 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:**