

This form must be completed annually, or sooner if the student's allergies change. It is to be filed in the Digital Student Record.

STUDENT INFORMATION (to be completed by Parent/Guardian or Independent Student)		
Student Name:		<i>Place Student Photo Here</i>
Date of Birth:	Home Phone:	
School:	Grade:	
Name of Parent/Guardian:	Daytime #:	
Emergency Contact:	Daytime #:	

<p>By initialling and signing below, I indicate that I understand why I have been asked to disclose the student's identifying information and am aware of the risks or benefits of consenting or refusing to consent to the disclosure.</p> <p>I give permission for the school to post and/or distribute photographs and medical information in key locations, such as classrooms, school uses, staff rooms, etc.</p> <p>I give consent for the school and personnel to assist with the administration of prescription medication in the event of an emergency.</p> <p>I give the school division consent to place a copy of this form in the student's cumulative student record.</p> <p>I understand that it is my responsibility to ensure that this information regarding my child's/my anaphylactic allergy remains current and up-to-date and that I will notify the school if there are any changes.</p>	
Signature of Parent/Guardian or Independent Student	Date
Signature of Principal	Date

REGISTERED PRESCRIBER INFORMATION (to be completed by Registered Prescriber)	
Medication Required on a Scheduled Basis (Name/Type):	
Dosage	Manner of Administration:
Medication Required on a Scheduled Basis (Name/Type):	
Dosage	Manner of Administration:
Describe possible hazards or side effects of medication(s)	
If such hazards or side effects materialize, the following steps should be taken:	
Describe actions to be taken if a dosage is missed:	
Describe actions in an emergency situation (i.e. when to call ambulance):	
Name of Registered Prescriber:	Phone #:
Signature of Registered Prescriber:	Date:

