CARONPORT HIGH • SCHOOL
A school of Briercrest College and Seminary

Consent for Medical Treatment and Administration of Medications During Enrolment at CHS

This form extends permission to staff of Briercrest College and Seminary and Caronport High School (referred to as BCS/CHS throughout) to administer medication and/or emergency treatment to CHS students during their enrolment with our school. This may include students' time in the school, in the dorm (if applicable) and during school activities, either curricular or co-curricular. Administration of medication cannot be provided without this completed and signed form.

Students travelling with CHS on curricular and co-curricular trips are allowed to self-administer their own medications as necessary; however, it is recognized that there may be times when a supervising BCS/CHS staff member may need to be involved in facilitating medical care for a student.

If you are the parent/guardian of a CHS student with a serious health concern, you are strongly encouraged to ensure that proper identification is on the student at all times (i.e., MedicAlert Bracelet); you are responsible for providing, in advance, medication/supplies for any treatment required in a life-threatening situation. These health concerns include, *but are not limited to*, severe allergies and anaphylactic shock, severe asthma, seizures and diabetes.

It is your responsibility to update us if there is a change in your son or daughter's health care.

Section A: Personal Data

Student's Name: _____ Date of Birth: (DD/MM/YY) _____
(Please Print) Family name Given names

Male ❒ Female ❒ Grade: 9 ❒ 10❒ 11❒ 12❒

Name of Parents/Legal Guardians:

Father: _____ Mother: _____

Home Phone: (___) _____ Home Phone: (___) _____

Work Phone: (___) _____ Work Phone: (___) _____

Cell Phone: (___) _____ Cell Phone: (___) _____

Home Address: _____ Home Address: _____

If applicable, who has legal custody: _____

Emergency Contacts:

1) Name: _____ 2) Name: _____

Relationship to the student: _____ Relationship to student: _____

Phone: (_____) _____ Phone: (_____) _____

Name of family physician: _____ Phone: (_____) _____

Section B: Medical Information

Provincial Health Services number: _____ Province: _____
(International students must apply upon arrival to campus for a Saskatchewan Health Card - No charge)

❒ My child has major health conditions. ❒ My child has no major health conditions.

Medical Conditions: (Please check & provide relevant details in the space provided below)

❒ Asthma (severity, inhalers, etc.) _____
❒ Diabetes (type) _____ (insulin) _____
❒ Epilepsy

Other Chronic Problems:
❒ Stomach problems
❒ Chronic tonsillitis

❒ Immune Deficiency ❒ Headaches
❒ Heart problems ❒ Skin problems
❒ Allergic reactions (please fill in "Allergy Reaction Information" section below
❒ Hospitalization /Surgery (in past year) _____
❒ Other (Please specify): _____

Details: _____
_____

Recommended procedures if a health problem occurs (for staff): _____
_____

Allergic Reaction Information: (Please specify)

Nature of Allergy/Allergens:

Medications	NO❒	YES❒	Name(s): _____
Food	NO❒	YES❒	Kind: _____
Environmental	NO❒	YES❒	Kind: _____
Insects	NO❒	YES❒	Kind: _____
Animal	NO❒	YES❒	Kind: _____
Plants	NO❒	YES❒	Kind: _____
Other	NO❒	YES❒	Kind: _____

Symptoms of Reaction: _____
Recommended Response to Reaction: _____
_____
Medication: _____ Dosage: _____
Additional Instructions or Information: _____
_____

If the reaction is severe, does the student have an EpiPen or a MedicAlert bracelet? NO❒ YES❒
Will you provide an extra EpiPen to the school and/or dorm staff for emergency use? NO❒ YES❒

Emotional Health: (Please check)

❒ Addictions ❒ Eating disorder ❒ Depression
❒ Anxiety ❒ Panic attacks ❒ Schizophrenia
❒ Other (Please specify): _____
❒ Inpatient program or Psychiatric care (in past year): _____
Additional Instructions or Information: _____
_____

Medications to be self-administered:

Is the student currently taking medication(s)? NO❒ YES❒ If so, please provide name(s) and dosage(s):
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Medications that you will allow CHS staff to provide to your child at his/her request:

❒ Tylenol Cold and Sinus ❒ Antacid ❒ Immodium (diarrhea)
❒ Tylenol ❒ Gravol ❒ Generic Muscle relaxant
❒ Advil Cold and Sinus ❒ Chlor-Tripolon ❒ Agarol (mild laxative)
❒ Advil (Ibuprofen) ❒ Benadryl
❒ Other: _____
❒ Requests or instructions: _____

Section C: Parental Consent

To be completed by parent/legal guardian if student is under the age of 18.

I, as the undersigned parent/legal guardian, do hereby give consent for _____

Name of student (please print clearly)

to undergo all necessary medical examinations, diagnostic tests, x-rays and treatments, including local anesthetic, that will be required in the course of diagnosis, examination and treatments of his/her illness or condition while a student at CHS, with the understanding that CHS/BCS staff may at that time give consent for treatment. Furthermore, this information may be forwarded to those individuals involved in insuring the provision of adequate health care while attending CHS (i.e., sports and ministry teams). In so giving this consent, the applicant and parent/legal guardian do jointly and severally remise, release and forever discharge BCS/CHS and further do jointly and severally indemnity and save harmless the said BCS/CHS from all manner of action or actions, cause or causes of action, suits, debts, dues, sums of money, claims, charges, liabilities, expenses, damages, losses and demands whatsoever at law or in equity that they may suffer or otherwise incur as a result of, in connection with, or in relation to any such medical examinations, diagnostic tests, x-rays and treatments as referred to above, provided that BCS/CHS and its employees, agents, representatives and/or professional advisors have acted or omitted to act in good faith.

Further, as parent/guardian of the above named student and on behalf of my child, I hereby request assistance from the staff of BCS/CHS, with the administration of medications to my child. I recognize that such staff members do not have nursing, medical or pharmaceutical training. I agree to provide updated orders when the stated medication is changed in dosage or application schedule. I hereby release BCS/CHS and its employees and volunteers from any responsibility for any error, injury or damage which may occur in connection with, or as a result of, the administration of medications, or the manner in which they are administered. I further waive any claims that either I or my child may have against BCS/CHS and/or any of its employees or volunteers arising out of, or in connection with, or as a result of the administration of medications or in the manner in which they are administered, notwithstanding that any such loss, injury or damage may have arisen in whole or in part, due to the fault or negligence of BCS/CHS and/or its employees or volunteers. And, I agree that this waiver shall be binding upon both myself and my child and our respective heirs, executors. I further acknowledge that I have been requested to execute this waiver in consideration of BCS/CHS, agreeing to permit its staff to assist in the administration of medications to my child.

NOTE: Information collected on this form will be used to provide care to you while you are a student at Caronport High School. We are committed to ensuring that your personal information remains confidential and private. This information will be disclosed, as necessary, only for the purposes that are considered reasonable in the particular circumstance. It will not be used to disclose personal information for any purpose other than that for which it was collected, or if you consent to specific disclosure. Only BCS/CHS and Prairie South School Division No. 210 authorized employees and volunteers will have access to your personal information and appropriate controls are in place to ensure the security of this information. Your file will be kept in compliance with Provincial regulations (usually 7-10 years). After this time, your file will be destroyed. You may at any time update, amend or request a copy of this document.

To the best of my knowledge all information I have given on this form is complete and true.

Signed: _____ Date: _____

Signature of Parent or Legal Guardian (if student is under 18 years of age)

Signed: _____ Date: _____

Student