**STURGEON COUNTY PROGRAMS**
 **MEDICATION INFORMATION FORM**

Name of Participant:

Emergency Contact: Name \_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important Notice:**

**All prescription medication** **brought with your child to the program including Epi-Pens and Puffers must be documented in this medication information form.**

Epi-Pens and/or Puffers will be retained by your child and will remain with them (on their body) for the duration of the program. They should be kept in a handbag or fanny pack.

All other prescription medication will be checked in with program staff. Medications will be kept in a locked box with Program Staff. Please send medications in single doses in plastic bag labeled with your child’s full name, date of birth and time they will be taking the prescription medication. If your child takes multiple medications, ensure they are all packaged in single doses, labeled and bagged separately, and labeled as detailed above.

Your child will be responsible to self-administer their medications at the appointed time. They will be advised by staff during the program when it is time to take their medications and will be provided the medication from the locked box.

**Parents/Guardians please ensure this check list is complete:** 🞏 Medication must be in packaged in single doses with package labeled with your **child’s full name**, **date of birth** and **time medication is to be taken**.

 🞏 Each dose must be in its own individual labeled bag.

 🞏 All prescription medications that will be with my child at the program have been documented on back of this form.

If you have questions or concerns, please call the office at 780-939-8334.

Parent/Guardian Signature Parent/Guardian Name (Print) Date

**Please complete back of form**

*Your personal information provided will be used to contact you in case of an emergency or to provide appropriate care to your child and is collected under the authority of Section 33 (c ), of the Freedom of Information and Protection of Privacy (FOIP) Act. If you have any questions regarding the collection and use of this information, please contact the Sturgeon County Access and Privacy Coordinator at 9613 – 100 Street, Morinville, Alberta, T8R 1L9, (780) 939.4321 or foip@sturgeoncounty.ca*

**Parents/Guardians**

Please complete all that will apply to your child during the time that they are in our program.

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| --- |
| *Please list all program names & number where your child will be attending with medications.* |
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My son/daughter will have the following medication on their person.

□ Epi-pen □ Other - Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Puffer

My son/daughter will bring the following medication packaged and labeled as per instruction on first page of this form. I understand that medication will be turned in at the registration desk at the conference and that my son/daughter will be responsible to administer their medications at the appropriate time as listed below.

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| --- | --- | --- | --- |
| Name of Medication | Time(s) to be administered | STAFF USEMedications Received (initial) | STAFF USEMedicationTaken (initial) |
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Special Instructions:

*(side effects, storage*

*requirements, etc.)*

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