Medication Administration Request Form

REF: Medication Administration and
Conditions of Enrolment

TO BE COMPLETED BY THE PARTICIPANT OR PARENT/LEGAL GUARDIAN OF THE PARTICIPANT

Participant's Name: **Participant/parent/guardian signature:** _____	**Participant's Date of Birth** _____ / _____ / _____ **MM DD YYYY**	**Participant address:**	**Participant Emergency Contact:** **Emergency Number:**

Name of Medication as it Appears on the Label	**P** = Prescription **NP** = Non-Prescription	**Medication Expiry Date**	**Treatment end date**	**Possible Side Effects (if any)**	**Administration Schedule (time to be given)**	**Dosage & Route**	**Storage Instructions**

Please indicate special instructions for taking medication (i.e. with meals, drink plenty of water).

Medication Administration Form Terms and Conditions

*****ATTACH SIGNED TERMS AND CONDITIONS FORM TO THE REGISTRATION FORM*****

PART 2 - TERMS AND CONDITIONS FOR OSCA STAFF TO ADMINISTER, SUPERVISE THE ADMINISTRATION OF, OR STORE PARTICIPANT MEDICATION

PLEASE READ CAREFULLY

1. I agree to provide OSCA staff with:
   - **a. In the case of Non-prescription Medication and Natural medicine**
     - i. Staff will ask for and receive a physician's written order before agreeing to administer, store or supervise the administration of *Non- Prescription Medication/ Alternative Medicine*. All non-prescription medication must be supplied in its original container, dated and labelled with the participant's name.
   - **b. In the case of Prescription medication**
     - i. will have the original pharmacist's label with the participant's name, the physician's name, the name of the medication, the dose, the medication route, the schedule for administration and instructions for storage.
   - **c. Photograph(s) – in the case of epinephrine auto-injectors**
     - i. **ONE photograph** that will be affixed to the Medication Administration Request Form.
   - d. **Two** Epipen® or two TwinJect® brand auto-injectors of epinephrine if my child suffers from life threatening allergies. The Epipen®/TwinJect® must be prescribed by a physician and labelled with the pharmacist label. I understand that I am responsible for regularly checking my child's Epipen®/TwinJect® for expiration and discoloration.
   - **e. I understand that in the case of the TwinJect® auto injector, OSCA staff will not administer the second dose but will use the second TwinJect® provided or an Epipen®.**
2. OSCA reserves the right to refuse the registrant's participation in the program if the above Terms and Conditions have not been follow.
3. Clients who require the use of emergency medication (i.e., Nitroglycerin, inhaler, Epipen) and come to OSCA programs without their medication will not be permitted to participate.
4. I agree that OSCA staff may refuse to administer, supervise the administration of, or store medication where the labels on the medication container(s) do not contain all the information specified above.
5. Any directions that deviate from the OSCA policy will be reviewed through consultation with the executive director or his/her designate on a case-by-case basis.
6. I understand that not all OSCA staff participating in the Medication Administration policy are trained health professionals and that the administration of medication is being provided by or, on behalf of OSCA, on a purely voluntary and gratuitous basis. As the Participant or Parent/Legal guardian of the Participant/Client receiving medication, I fully understand the nature and extent of the risks involved in administering medication.

I confirm that I have read and understood and completed this agreement and the Enrolment form. I am aware that by signing this agreement I have agreed to assume full legal liability for all risks involved in having OSCA administer medication under the provisions of this agreement to the named participant.

I authorize OSCA staff to (please check the appropriate box)**:**

- ☐ Supervise the named participant in the administration of his/her own medication.
- ☐ Administer medication to the named participant.
- ☐ Share personal and confidential information in the case of an emergency responder.

Name of Participant or Parent/Guardian *if Participant is under the age of 18 or an adult who lacks the capacity to provide informed consent (please print).*

Signature of Participant or Parent/Guardian *if Participant is under the age of 18 or an adult who lacks the capacity to provide informed consent.*

Date: __/_____/ _____
MM DD YYYY