POLICY # G.1.K. EX2

Managing Health Care- Medical Consent Form

HEALTH CARE CONSENT FORM

Student's name: _____

Date of birth: _____

Parent/Legal Guardian: _____

Your students safety and well-being is a priority for us. To help keep your student safe and healthy, we may need to provide health care treatment to your student, while he or she is a student at our school.

However, we cannot provide health care treatment to your student without consent to do so. **By signing this consent form, you are agreeing that we can provide the following health care treatment to your student**:

1. **First aid treatment**, performed by our staff. This means that we can give treatment to your student for injuries like minor scratches, cuts, burns and splinters.

2. We can give the following **non-prescription medication** to your student, for the purpose of treating "acute self-limiting conditions". This means that we can give your student the **non-prescription medication** that is listed below for minor medical conditions that will resolve themselves without the need for further treatment, such as headaches, colds and upset stomachs:

Acetaminophen (e.g. Tylenol)	Antacid (e.g. Tums)	Antibiotic cream (e.g. Polysporin)
Antihistamines (e.g. Benadryl)	Calamine lotion	Ibuprofen (e.g. Advil)
Cough Medicine		Orajel-(tooth pain reliever)
Throat lozenges		

We will follow the instructions that come with this medication, when we give it to your student. **If you do not want your student to receive a particular kind of medication, please cross out the medication from the list above**.

3. We can give **prescription medication** to your student, but only if you tell us we can. Should your student be prescribed medication, by a health care provider, you will be contacted by a Youth Care Leader from Southeast College to discuss the prescription. You will be asked for **Verbal consent** each time a prescription has been prescribed for your son/daughter. This **verbal consent** is for Southeast to disburse to your son/daughter. A Youth Care Leader will complete a **RECORD OF ADMINISTERED PRESCRIBED MEDICATION** form (G.1.K – EX1), to track the prescribed medication and dosage for your student.

4. As part of our commitment to your student's health and wellness, we can take your student to or from a doctor and/or a hospital or health care facility, such as a dentist, for treatment. Please note that we are not responsible for ensuring that you have consented to any such treatment that the doctor/and or hospital or health care facility may prescribe. Rather, this consent form only allows us to take your student to these appointments, which may include doctor's appointments, dentist's appointments, physiotherapy, and teen health Clinic.

   Please check off the boxes below if you **do not** want us to take your student to any of the following places, for the purpose of providing treatment. You can also give us further instructions by writing in the box marked "other":

____ Dentist appointment	____ Medical doctor's appointment	Other:
____ Teen health counseling (pregnancy, drug or alcohol awareness)		

This consent form **does not** authorize us to consent to treatment for serious injuries on your student's behalf. We cannot consent to treatment for head, dental or other injuries, seizures or illnesses that require further medical treatment at a hospital or a doctor's office. You will be notified of all emergencies.

Please be aware that, in some situations, your student may be capable of providing consent to medical treatment for him or herself. If your student is able to understand the nature and effects of medical treatment, we may be **required by law** to respect your student's choices, even if they are different than yours. Your student may also have a legal right to keep us from telling you about his or her health information, even though you have signed this consent form. While we are committed to keeping you informed about your student's health, we must also follow these legal requirements.

This consent will be effective for as long as your student is a student at Southeast College, unless and until it is withdrawn by you, in writing. If you no longer wish to consent to health care

treatment for your student, or if you want to change this form, please contact our Receptionist office at 204-261-3551.

By signing this consent form, you agree that we can collect, use and share your students medical information for the purpose of providing the treatment that is authorized by this form. This information is handled in accordance with ss. 21 and 22 of *The Personal Health Information Act* and ss. 43 and 44 of *The Freedom of Information and Protection of Privacy Act*.

Your signature confirms that you agree to release Southeast College and its representatives, agents, and successors from any liability related to the administration of health care treatment that is authorized by this form, as long as that health care treatment is provided reasonably and in good faith.

DATE: _____ Parent/Guardian Signature: _____

DATE: _____ Student Signature: _____

This contract expires June 30th of the current school year or when the student leaves Southeast College or if there is a change in either custody or legal guardianship, in which case, a new form must be completed.

Adoption Date: August 21/12	Revision Date: March 11/16