Living Sky School Division No. 202

Growth Without Limits, Learning For All

5.37B – Prescription Drug Impairment Disclosure

Name of Employee_____ D.O.B. _____

1. Date of last attendance on:_____
   Date of next clinical review: _____

2. Has the employee been referred to a specialist who would have relevant information concerning the issues discussed in this report?
   No_____ Yes _____ to Dr._____

3. In your opinion, is the employee fit for full-time attendance at work?
   Yes_____ No_____
   If no, in your opinion, on what date can we expect the employee will be fit for full-time attendance?
   _____

4. Please identify the specific medical restrictions or limitations that may affect the employee at school.

Description of restriction/s	Expected duration of restriction/s
_____	_____
_____	_____
_____	_____
_____	_____

5. Is the employee taking any medication which **must** be taken during the work day (between _____ AM and _____PM)? Yes_____ No_____
   If Yes:

Name of medication	Dosage	Time/s
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. We understand that this employee has been prescribed medical marijuana. If this is the case:
   a) In what form is the medical marijuana currently administered? Please provide details:
   _____
   _____
   _____

b) Can it be administered in another form? Please provide details _____

_____

_____

c) Does the amount prescribed for each dose affect the employee's mental or physical functions in any way?
Yes _____ No_____
If yes, in what manner, and for what duration: _____

_____

_____

d) Are there any other medications, or actions, treatments or therapies that the employee could take or use as an alternative measure during the work day? Yes _____ No_____ Please explain.

_____

_____

_____

e) Have you prescribed any other treatments for the employee*?*
Yes _____ No_____
If yes, to the best of your knowledge, is the employee following such advice?
Yes_____ No_____

f) Does the employee take any other medications or treatments that affect the employee's mental or physical functions in any way? Yes _____ No_____
If yes, in what manner, and for what duration: _____

_____

_____

7. Please provide any additional information that you feel would be pertinent and beneficial:

_____

_____

_____

Signature of Physician: _____ Date: _____

(Please print name or provide stamp_____)

Please scan and email this form to the confidential email: hr@lskysd.ca, or alternatively mail to:

Living Sky School Division – HR (Confidential)
509 Pioneer Avenue
North Battleford, SK S9A 4A5