PRESCRIPTION MEDICATION
IMPAIRMENT RISK ASSESSMENT FORM

Student Name:

To be completed and signed by the appropriate physician, pharmacist and/or applicable health professional. A separate form is required for each prescription medication. Please attach a copy of the prescription to each completed form.

NOTE: This Student has been identified to be studying in a safety-sensitive program at NBCC. This means that a serious risk of physical harm to the Student, fellow students and/or the public exists if the Student operates in a state of impairment at NBCC. In order to ensure NBCC meets its legal duties, pursuant to the NB *Occupational Health & Safety Act* and the *Human Rights Act* (to be aware of any risk of harm and meet its duty to accommodate disability), more detailed information is required to verify any potential impairment(s) associated with the medication(s) prescribed to this Student.

Medication:

A. Risk of Impairment: ☐ **No** ***(complete Section C)*** ☐ **Yes** ***(complete Sections B & C)***

B. Impairment(s) Associated with the Prescribed Medication for this Student:

Please check appropriate boxes to indicate and describe nature of potential impairment. Numbers from 1 to 4 indicate the level of impairment (1 being minimal impairment to function and 4 being high impairment to function).

Impairment to Function	0	1	2	3	4	Comments / Details
1. Muscle Control						
2. Vision						
3. Hearing						
4. Speech						
5. Sleep (causing fatigue)						
6. Concentration						
7. Memory						
8. Performance of multiple tasks						
9. Other:						

Additional Comments:

C. Health Professional's Data

Print Name:

Professional Designation (e.g. Doctor / Pharmacist / Other):

Signature: **Date:**

Contact (for follow-up questions): Email: **Telephone:**