River East Transcona
SCHOOL DIVISION

589 ROCH STREET, WINNIPEG, MANITOBA R2K 2P7
P 204.667.7130 F 204.661.5618 www.retsd.mb.ca

Authorization for the Administration of Medication to Students

To be completed by Parent/Guardian

Student Identification

Name _____
Year Month Day

Date of Birth: _____

Phone # _____

Address _____

MHSC # _____

PHIN # _____

Parent/Guardian Identification

Father's Name _____

Work # _____

Cell # _____

Mother's Name _____

Work # _____

Cell # _____

School Identification

Name of School: _____

Address: _____

Phone # _____

Physician Identification

Name _____

Address: _____

Phone # _____

Emergency Contact if Unable to Reach Parent/Guardian

Name _____ Phone # _____

Confirm that the first dose was administered and no adverse reactions occurred prior to coming to school: Yes ❍ No ❍

_____
Signature: Parent/Guardian

To be completed by Parent/Guardian in Consultation with Physician and Pharmacist

Medication Information:

Name of Physician Consulted: _____ Phone # _____

Name of Pharmacist Consulted: _____ Phone # _____

Name of Medication _____

Reason for Medication _____

Dosage and Method of Administration _____

Approximate time(s) of administration during school day _____

_____

Specific Storage Requirements _____

Side effects to watch for and actions required if these side effects are observed _____

_____

Action required if medication is missed _____

Parent/Guardian Authorization

I have read the attached policy and regulation and hereby request and authorize the school to administer the prescribed medication to my child in accordance with the regulation, including that:

(1) medications presented to a school not meeting the conditions of this regulation cannot be administered by school division staff. The parent/guardian retains full responsibility for administering the medication.

(2) The parent/guardian or designated adult is responsible for the delivery and supply of the medication. If requested, pharmacies will provide two original pharmacy labeled containers.

(3) The medication container must have the dispensing instructions noted on it and must have the official label of the pharmacy:

- name of the student
- name of the prescribing physician
- name of the pharmacy
- dose
- frequency and method of administration
- name of the medication
- date the prescription was filled

(4) It is the responsibility of the parent/guardian to notify the school in writing of any changes in dosage or time of administration of medication.

(5) The designated employee (or alternate) is to administer the prescribed medication.

(6) Authorization must be renewed annually with student registration or upon change in medication.

I hereby request and authorize the school to administer the prescribed medication to my child. I also certify that the first dosage of medication was given at home and no adverse reactions were tolerated. School personnel are authorized to contact the physician/pharmacist regarding any questions as to the administration of this medication.

_____ _____

Date Signature of Parent/Guardian

OR

I hereby certify that _____ (student's name) is able to safely, competently and consistently manage his/her own medication, and I authorize the self-administration of the medication _____ (name of medication). I understand that I am responsible for consequences which may result from lost or misplaced medications.

_____ _____

Date Signature of Parent/Guardian

Office Use

Individual Administering Medication: _____ Date Trained: _____

Signature: _____

Alternate: Name: _____ Date Trained: _____

Signature: _____

Training Provided by: _____

_____

Administrator Signature