ST. JAMES-ASSINIBOIA SCHOOL DIVISION JLCD-E-1

AUTHORIZATION AND ADMINISTRATION OF PRESCRIBED MEDICATION

(Prescription or Over-the-counter)

PART I - IDENTIFICATION

Student Identification:

Name: _____ Birthdate _____/_____/_____
Year Month Day

Manitoba Health Number is on file ☐ Yes ☐ No

School Identification:

School name: _____ School year: _____

Parent Identification:

Parent/guardian _____ Day phone(s) _____

Parent/guardian _____ Day phone(s) _____

Emergency contact _____ Day phone(s) _____

Physician Identification: Name: _____ Phone:_____

Physician Address: _____

PART II - MEDICATION INFORMATION - TO BE COMPLETED BY THE PARENT/GUARDIAN OR PHYSICIAN

Name of medication _____

Reason for medication _____

Dosage _____ Time of administration during school day _____

Route (e.g. oral, eye drops) _____

Start date (if applicable) _____ End date (if applicable) _____

Storage requirements (e.g. refrigeration) _____

Physician that prescribed medication _____

Phone:_____

Address _____

**Continued on next page

I understand that my child's personal and personal health information will be kept confidential and protected in accordance with FIPPA and PHIA. I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA. If you have any questions or concerns about the collection of this information, contact the Access and Privacy Officer at the St. James-Assiniboia School Division, 2574 Portage Avenue, Wpg, MB R3J 0H8, telephone (204) 888-7951.

PART III - PARENT/GUARDIAN AUTHORIZATION*

Student Name _____

School name: _____ **School year:** _____

I have read and understand policy JLCD and regulation JLCD-R - Administering Medicines to Students Prescribed and Over-The-Counter, and I understand that:

☐ Yes, the first dose of the above medication has been administered at home and well tolerated. *The first dose does not need to be administered at home if the medication is required for emergency situations (e.g. adrenaline auto-injector for anaphylaxis, reliever medication for asthma, rescue medication for seizures).*

☐ I have attached the original pharmacy prescription label to this form or the OTC medication is in its original container.

I hereby certify that the above information is correct and request and authorize the school to administer the medication named above to my child.

_____

Please Print Parent/guardian name

_____ _____

Parent/guardian signature Date

**This authorization automatically terminates June 30th of the current school year or upon change in medication.*
Revised June 27, 2017 Motion #11-03-17

I understand that my child's personal and personal health information will be kept confidential and protected in accordance with FIPPA and PHIA. I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA. If you have any questions or concerns about the collection of this information, contact the Access and Privacy Officer at the St. James-Assiniboia School Division, 2574 Portage Avenue, Wpg, MB R3J 0H8, telephone (204) 888-7951.