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 ____

Physician signature: ____
(required for over the counter medication only

**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.

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

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