Pembina Trails School Division
*Accomplish Anything*

**JLCD-E-1**
**AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION** (Prescription or Over-the-Counter)

## IDENTIFICATION (to be completed by the Parent/Guardian)

**Student Identification:**

Name: _____
Surname First Middle

Birthdate: _____ M.H.S.C #: _____ P.H.I.N. #: _____
Day Month Year

Address: _____ Phone: _____
Street Number City/Province Postal Code

**School Identification:**

Name of School: _____

Address: _____ Phone: _____
Street Number City/Province Postal Code

**Parent/Guardian Identification:**

Name(s): _____

Address: _____
Street Number City/Province Postal Code

Mother Work #: _____ Father Work #: _____

**Physician Identification:**

Name: _____

Address: _____ Phone: _____
Street Number City/Province Postal Code

**Emergency contact if unable to reach parent/guardian:**

Name: _____ Phone: _____

## MEDICATION (to be completed by the Parent/Guardian in consultation with Physician and/or Pharmacist)

Name of Physician Consulted: _____ Phone: _____

Name of Pharmacist Consulted: _____ Phone: _____

Name of Medication(s): _____

Reason for Medication(s): _____

Dosage and Method of Administration: _____

Approximate time(s) of administration during the school day: _____

Start Date: _____ End Date: _____
Day Month Year Day Month Year

Specific storage requirements: _____

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

_____

Action required if medication is missed: _____

_____

**Note: The first dosage of medication should be administered at home.**

## PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION

a) Medications presented to a school not meeting the conditions of this policy will not be administered by divisional staff. The parent/guardian retains full responsibility for administering the medication.
b) The parent/guardian must provide a recent photo (school picture) of their child.
c) The parent/guardian or designated adult is responsible for the delivery and supply of the medication. If requested, pharmacies will provide two original pharmacy labelled containers.
d) The medication container must have the dispensing instructions noted on it and must have the official label of the pharmacy.
e) 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.
f) The school administrator (or designate) is to administer the prescribed medication.
g) Authorization automatically terminates June 30th of the current school year or upon change in medication.

❑ I hereby request and authorize the school to administer the prescribed medication to my child. I have provided a recent photo (school picture) of my child. I also certify that the first dosage of the medication was given at home and was well tolerated. School personnel are authorized to contact the physician/ pharmacist regarding any questions as to the administration of the medication.

| Parent/Guardian Signature | Date |
|---|---|
| | |

**School Use Only**

Date: _____

Staff Designate who will administer medication: _____

Signature: _____ Date trained: _____

Alternate - Name: _____

Signature: _____ Date trained: _____

Training provided by: _____

| Administrator Signature | Date |
|---|---|
| | |

**Original authorization to be retained in student's cum file. This authorization automatically terminates June 30th of the current school year or upon change in medication.**