# AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

***(file in student file & medication binder)***

School: Robert Smith School Date: _____

**Student Contacts:**

Student Name: _____ Date of Birth: _____

MB Health PHIN: _____

Parent/Guardian Name: _____ Daytime Phone: _____

Emergency Contact: _____ Daytime Phone: _____

**Medical Contacts:**

Prescribing Doctor: _____ Phone #: _____

Address: _____

Pharmacy Name & Location: _____

**Medication Information**: (***Parent to consult with Dr. or Pharmacist, if needed)***

Name of Medication: _____

Reason for Medication: _____

Method of Administration: _____

Dosage of Medication: _____

Time(s) of Administration during school hours: _____

Specific storage requirements (if any):_____

Possible side effects & actions required if side effects occur:

_____

Stop medication if the following reactions occur:

_____

**MEDICATION ADMINISTRATION REQUIREMENTS:**

1. The parent/guardian is responsible to deliver, in person or via a responsible adult, the supply of medication for school use in an **original, pharmacy-labelled container** which clearly identifies the name of the child, name of the medication, dose, frequency/time and route of administration, name of the licensed medical practitioner, name of the pharmacy, and date the prescription was filled. This container must be strictly for school use. If required, measuring implements must be provided.

2. Parent/guardian is responsible to ensure a supply of medication is maintained, that expired medications are replaced, and that expired medication is removed from the school for disposal.

3. **School staff will never administer the first dose of any new medication prescription. Parent/guardian is responsible for administering the first dose of any new medication or increase in dosage and ensuring that it has been well-tolerated.**

4. A designated staff member, or in their absence an alternate staff member, will administer the medication as prescribed.

This medical information is being collected so that appropriate plans may be developed and will only be shared with appropriate individuals.
This information is protected under The Freedom of Information and Protection of Privacy Act and the Personal Health Information Act.

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**PARENT/GUARDIAN CONSENT:**

I have read and understand the Medication Administration Requirements. I hereby request and authorize the school to administer the prescribed medication to my child during school hours. School personnel are authorized to contact the physician or pharmacist regarding any questions as to the administration of the medication.

Signature of Parent/Guardian: _____

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**For School Use Only:**

Start Date of Medication: _____

Stop Date of Medication: _____

Designated Person to Administer Medication: _____

Alternate: _____

Signature of Administrator: _____