Pembina Trails School Division
Accomplish Anything

JLCD-E-5
AUTHORIZATION FOR THE SELF-ADMINISTRATION OF PRESCRIBED MEDICATION (Prescription or Over-the-Counter)

PERSONAL INFORMATION (Please Print)

Student Name: _____ Birthdate: _____
Month Day Year

M.H.S.C. # _____ P.H.I.N. # _____

Address: _____
Street Address City/Town Province Postal Code

Phone: _____ Present School: _____

Parent/Guardian: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

MEDICAL INFORMATION

Name of prescribing physician: _____ Phone: _____

If prescription medication:
Name of medication (as indicated on the pharmacy label) _____

If over-the-counter (O.T.C.) medication:
Name of medication (as indicated on the manufacturer's label) _____

PARENT/GUARDIAN AUTHORIZATION

❑ I have read the Pembina Trails School Division Administration of Prescribed Medication Policy and I understand that:

a) Medication for students must be brought to school in a container that clearly indicates the name of the student and medication.
b) Students in elementary and middle years schools will be required to bring and store narcotic medications (e.g. Ritalin, Demerol, morphine, etc.) in the office.

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

Parent/Guardian 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.