AP 2-336 – AUTHORIZATION TO SELF-ADMINISTER PRESCRIBED MEDICATION

Date: _____

PERSONAL INFORMATION

Student Name _____ Birth date _____/ _____/ _____
y m d

Student Manitoba Health Number # _____ Personal #_____

Parent/Guardian Name _____

Home Phone # _____ Work Phone # _____ Cellular Phone # _____

Emergency Contact _____ Emergency Contact # _____

MEDICATION INFORMATION

Name and dosage of medication_____
(as indicated on the pharmacy or manufacturer's label)

PARENT/GUARDIAN AUTHORIZATION

I have read the Western School Division Administration of Medication Procedure (AP 2-333) and I understand that:

(a) Medication for the student must be brought to school in a container that clearly indicates the name of the student as well as the name of the medication.

(b) Parents will be required to bring and store controlled substance and narcotic medications (i.e. Ritalin, Codeine, etc.) in the office.

(c) Only the required daily dosage should be brought to school.

I hereby certify that _____ is able to safely, competently and consistently
(name of student)

manage his/her own medication and authorize the self-administration of _____.
(name of medication)

_____ _____
Signature of Parent/Guardian Date

This authorization automatically terminates on June 30th of the current year or upon change in medication (with exception of urgently required medications such as adrenaline auto-injectors or bronchodilators).

Adopted: **February, 2004**

Revised: **October 2017**