Prairie Rose School Division

Authorization for the Self-Administration of Prescribed Medication

(Prescription or Over-the-Counter)

Please print the following information required.

PERSONAL INFORMATION

Student Name ____ Birthdate _____/_____/_____
Year Month Day

M.H.S.C. # ____ P.H.I.N. # ________________________

Address ____ Phone __________________________

Present School
____

Parent/Guardian ______________________________________ Work Number ____________________

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 manufacturer's label) ___________________________________

PARENT/GUARDIAN AUTHORIZATION

I have read the Prairie Rose 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) All students 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 loss of misplaced medications.

Signature of Parent/Guardian ________________________________ 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.