St. James-Assiniboia School Division
Administration of Prescribed Medication

The St. James-Assiniboia School Division acknowledges the fact that certain students may require prescribed medication during the school day in order to function as near to their potential as possible. The Division will attend to the administering of prescribed oral medication provided that school staff assistance is required in administering the medication and only if the parent(s) or legal guardian(s) of the student complete (and arrange for completion of) this form. Parent(s) shall complete a new form each school year and/or whenever the physician changes the prescription.

PART I – TO BE COMPLETED BY THE PARENT OR GUARDIAN

a. I request that the medication _____ be administered to:
(Name of Medication)

_____ Born: _____
(Name of Student)

b. The reason for the medication is: _____

c. The medication will be delivered to the school by: _____
(Name of adult)

d. I shall notify the school immediately if the medication is no longer required. ☐ Yes

e. In the event of problems administering the medication and I cannot be reached please contact: _____ (204) _____ - _____
(Name) (Phone Number)

f. Our Manitoba Health Commission Number is: _____ _____
(6 digit) (9 digit)

g. I hereby certify that the first **24 hours** of the medication was given at home and was well-tolerated.

Notes: _____

_____

h. Our Family Physician is:
Name: _____
Address: _____
Phone: _____ - _____ - _____

I understand that my child's personal and personal health information will be kept confidential and protected in accordance with The Freedom of Information and Protection of Privacy Act (FIPPA) and The Personal Health Information Act (PHIA). I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA. If you have any questions or concerns about the collection of this information, contact the Access and Privacy Officer at the St. James-Assiniboia School Division, 2574 Portage Avenue, Winnipeg, MB R3J 0H8, telephone (204) 888-7951.

i. Pharmacy Information.
The prescription was filled at the:

Pharmacy: _____

Address: _____

Phone: (204) - ____

I hereby certify that the above information is correct.

_____
(Signature of Parent or Guardian)

Address: _____

Phone: (204) - / (204) - _____

Date: _____

*(**Continued on next page – Part 2 – to be completed by Prescribing Physician)*

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PART II – TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN

Re: _____
(Name of Student)

A. Please attach a copy of the prescription and recommended dosage or write the same information in the following space:

_____

_____

_____

B. Specify the frequency and the method of administration of this medication during the school day:

_____

_____

_____

C. I anticipate the child's reactions to the prescribed medication will be:

_____

_____

_____

D. Potential Side-effects:

_____

_____

_____

E. Special storage instructions, if any:

_____

_____

_____

_____ _____

Physician's Signature Date

APPROVED June 22, 2004 Motion #16-03-04

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