WINNIPEG SCHOOL DIVISION
INVESTING IN THE FUTURE

Authorization for the Administration of Prescribed Medication

Student _____ Date of Birth _____

(Last Name/First Name/ Second Name) (Day/Month/Year)

School _____ Parent/Guardian _____

I/we _____, the parent(s)/guardian(s) of _____,
request assistance with the administration of the following medication:

Medication:_____ Dosage:_____ Time:_____

Give medicine: by mouth □ under the tongue □ into the right ear □ into the left ear □

into both ears □ into the right eye□ into the left eye□ into both eyes □

Apply to skin (specify area) _____

during school hours for my child for the following time period; from _____ to _____

(date) (date)

Physician's name: _____ Phone #: _____

Emergency Contact—Name: _____ Phone #: _____

The first dose has been administered and well tolerated at home:
- ○ **YES**
- ○ **NO (if no, the school cannot accept, first dosage must be given at home)**

_____ _____

Signature of Parent/Guardian **Date**

<u>For Office Use Only</u> - Refer to the Administrative Rule;
JHC-R(1) - Administering Medication to students

This personal health information is being collected under the authority of the ***The Public Schools Act*** for purposes related to the provision of educational programs and/or services supporting the student's educational progress and to ensure the health and safety of the student. It is protected by the privacy provisions of the ***Freedom of Information and Protection of Privacy Act*** and the ***Personal Health Information Act***. If you have any questions about the collection, please contact your school principal or the nurse educator at 788-0203, ext. 135.

September 2011