



### **AUTHORIZATION FOR ADMINISTRATION OF PRESCRIBED MEDICATION**

The Portage la Prairie School Division recognizes that certain students may require prescribed medication during the school day and agrees to administer the medication ***provided that*** school staff assistance is required and ***only after*** the parent(s)/legal guardian(s) have completed this form and it is delivered to the school with the required medication. It is also the responsibility of the parent/guardian to deliver refills for prescriptions as required. A new form must be completed each school year, and whenever the physician changes the prescription.

#### **TO BE COMPLETED BY PARENT/GUARDIAN**

Parent/Guardian: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
(home) (work)

request that the medication \_\_\_\_\_  
(name of medication)

\_\_\_\_\_ be administered at \_\_\_\_\_  
(dosage) (how often and time of day)

to \_\_\_\_\_ for \_\_\_\_\_  
(name of student & Personal Health Identification Number-PHIN) [period of time  
(days/weeks)]

as prescribed by Dr. \_\_\_\_\_  
(name of physician)

I will be responsible to send/deliver the medication to the school. If I am unable to do this personally, I designate the following person to deliver the medication to the school:

If the school has to call me because of some problem with the medication, I can be contacted at the following phone number(s): \_\_\_\_\_

If the school is unsuccessful in contacting me, please call the following emergency contacts:

Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_

I confirm that my child has already taken at least one dose of this medication in my presence and has tolerated it well. I will notify the school immediately if the medication is no longer required.

Date Approved: July 10, 2010	Date Reviewed:	Date Revised: April 14, 2025	Page 1
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I hereby release the Division and its employees from any claims of liability resulting from the administration of the medication provided that it is administered in accordance with this request and with Division Policy.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
School Year

\_\_\_\_\_  
Complete Address including Postal Code

**TO BE COMPLETED BY SCHOOL PERSONNEL**

We have read the above information.

\_\_\_\_\_  
Principal

\_\_\_\_\_  
Classroom Teacher