

PERSONAL INFORMATION (Please Print)

Student Name: _____ Birthdate: _____
Day Month Year

M.H.S.C. # _____ P.H.I.N. # _____

Address: _____
Street Address City/Town Province Postal Code

Phone: _____ Present School: _____

Parent/Guardian: _____ Work Phone: _____

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 the manufacturer's label) _____

PARENT/GUARDIAN AUTHORIZATION

- I have read the Pembina Trails 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) Students in elementary and middle years schools 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 lost or misplaced medications.

Parent/Guardian Signature	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.