



Education and Training

K-12 Education Division
Inclusion Support Branch
Manitoba School for the Deaf
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**AUTHORIZATION FOR THE ADMINISTRATION OF
NON-PRESCRIPTION MEDICATION
(PLEASE KEEP THIS FORM AT HOME UNTIL NEEDED)**

Name of Student: _____

Name of Medication: _____

Reason for Medication: _____

Dosage (tablet/tsp/ml/mg)

Administration Procedure

Time(s) the Medication is to be Given

Start Date: _____

End Date: _____

Specific Storage Requirements: _____

Return Home Daily: _____

Keep at School: _____

Date

Signature of Parent/Guardian