PHARMACISTS MANITOBA

Authorization to use non-child resistant vials

Patient Name: _____

DOB: _____

Pharmacy Name: _____

☐ Non-child resistant vials ☐ Medication organizer

Please check off the applicable boxes

Reason for non-child resistant vial: _____

_____

_____

I,_____, hereby authorize_____to dispense my medications in a non-child resistant (non-safety) vial(s) and/or medication compliance pack. I understand that these are not child resistant and therefore must be stored in an area not accessible to anyone except myself or a primary caregiver.

_____ _____

Patient Signature Date