Authorization for Administration of Medication at School

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route	Start Date	Stop Date

(All authorizations expire at the end of the school year or at the end of Extended School Year summer school programs)

Print or Type Name of Physician / Licensed Prescriber _____ Signature of Physician / Licensed Prescriber

Clinic Address _____ Fax Number _____ Phone Number _____ Date _____

Parent / Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request that the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking medication(s).
3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
4. I give permission for the school nurse or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
6. **I give permission for the school nurse or designee to consult (in oral or written format) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to physician/licensed prescriber and parent/guardian via monitoring form.**

☐ My son/daughter may self-administer his/her inhaler/Epipen®, if appropriate as assessed by the School Nurse.

Parent/Guardian Signature _____ Relationship to Student _____

Home Phone _____ Day Phone _____ Date _____

NOTE: Medication is to be supplied in the original/prescription bottle.

* Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect educational outcomes or this student's safety.

District Fax Numbers

East Central: 320-245-2448

Hinckley Finlayson: 320-384-6135

Pine City: (320) 629-4205

Rush City: Elementary (320) 358-1361; High School (320) 358-1261

Student Name: **Time:**

Medication: **Dosage:**

Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30	30	30	30	30
	31		31	31		31		31	
Signature Key:									