

## Authorization for Administration of Medication at School

Name of Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_

| Medical Condition | Medication | Strength<br>Mg/ml | Dose<br># Tablets | Time(s)<br>Frequency | Route | Start Date | Stop Date |
|-------------------|------------|-------------------|-------------------|----------------------|-------|------------|-----------|
|                   |            |                   |                   |                      |       |            |           |
|                   |            |                   |                   |                      |       |            |           |
|                   |            |                   |                   |                      |       |            |           |

(All authorizations expire at the end of the school year).

\_\_\_\_\_  
 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 give 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 medications(s).
5. I give permission for the medications(s) to be given by designated personnel as delegated by the school nurse or director.
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.

The above named student 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 original prescription bottle. Signatures must be completed in order to administer medication.**

**District Fax Number: 651-464-4429**  
**District Phone Number; 651-464--0771**  
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