AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

School Year: _____ School(Please check one): JES_____ JMS_____ JHS _____

Name of Student:_____Birthdate:_____ Grade:_____

Minnesota State Law requires a physician's order each school year for all prescription medications. Physician orders must be received before medication will be administered at school. Over-the-counter medications require parent/guardian signature. **ALL Medications must be in the original container, unopened, and unexpired**. Prescription medications must have the original pharmacy label. Any medication that is **NOT** in the **ORIGINAL PACKAGE, OPENED and/or EXPIRED will not be administered**.

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						
4.						

Other considerations/directions:_____

Start Date:_____Stop Date: _____ *(All authorizations expire at the end of the year)

☐ Student may self-administer_____(Not applicable for controlled substances)
fill in medication

☐ Student is knowledgeable about and may safely possess and use an inhaler.

Licensed Provider Signature

_____ _____
Signature of Physician/Licensed Prescriber Printed Name of Licensed Prescriber

_____ _____ _____
Date Clinic Address/Phone Number ICD-10#

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's licensed prescriber. I also request 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 the medication(s).
3. I will notify the school of any change in the medication(s) i.e. dosage change, medication discontinued, etc.
4. I give permission for the school nurse to consult with the above named licensed prescriber regarding any questions that may arise regarding listed medication(s), or medical condition(s) being treated by the medication(s).
5. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ _____ _____
Date Parent/Guardian Signature Phone #