Authorization for Medication Administration at School

ISD 282 St. Anthony/New Brighton Schools

Student: ____ **Birthdate:** _____________ **Grade:** _________
School: WP SAMS SAVHS (circle one) **Teacher (WP)** ______________ **School Year:** __________________

LICENSED PRESCRIBER'S ORDERS FOR ADMINISTRATION AT SCHOOL:

Medication	Dose	Time	Route	Reason for Medication:	Side effects?

Other directions or considerations:
____
____

Medication Allergies: ____
Start Date: ______________________ **Stop Date:** ____________________

(NOTE: All medication authorizations expire at the end of the school year or summer session.)

Licensed Prescriber Signature: ____ **Date:** _________________

Printed name of Prescriber: ____
Clinic Address: ____ **Phone:** ________________

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL:

1. I request that the above medication(s) be given during school hours as prescribed.
2. ALL MEDICATIONS SENT TO SCHOOL WILL BE IN AN APPROPRIATELY LABELED PHARMACY CONTAINER.
3. I also request the medication(s) be given on field trips by a teacher or responsible adult.
4. I will notify the school of any changes in the medication(s) and provide an updated authorization from the licensed prescriber.
5. I give permission for the medication(s) to be given by school staff as delegated, trained, and supervised by the school nurse.
6. I give permission for the school nurse to inform other school staff, as needed, about my child's medical condition and medication action.
7. I give permission to the school nurse to communicate with the licensed prescriber regarding any questions about the administration of the above medication(s) or medical diagnosis being treated by the medication(s).
8. I give permission to the licensed prescriber to release information to the school nurse regarding the above medication(s) and medical condition being treated.
9. Legally, you may refuse to sign for the medication. If you choose not to sign, the school will not be able to administer the medication at school.
10. This consent may be revoked at any time by sending a written notice to the school nurse.

_____ Check here if your elementary student attends Village Kids and you would like VK to have access to their medications during the school year.

Parents must provide all medications that are ordered except Tylenol (acetaminophen) which is available in the Health Offices.

Parent Signature: ____ **Date:** _________________

WP FAX: 612-706-1240 **SAMS FAX: 612-706-1040** **SAVHS FAX: 612-706-1140**