Owatonna Public Schools
Health Services Office

Medication Request and Physician Authorization

Please Type or Print:
Student Name: _____ Date of Birth: _____
Last First MI

Name of Medication: _____
Method of Administration: _____
Dose of Medication: _____
Time of Day to be given in School: _____
Diagnosis and Medical Reason for Medication: _____
ICD-10: _____

Physician Signature: _____ Date: _____
(Medication orders must be renewed at the beginning of each school year.)

Clinic Name: _____ Physician Telephone #: _____
Clinic Address: _____ Clinic Fax #: _____

Owatonna Public School's Fax: #'s

Lincoln Elementary:	(507)444 - 8199	Owatonna Middle School:	(507)444 - 8797
McKinley Elementary:	(507)444 - 8299	Owatonna High School:	(507)444 - 8999
Washington Elementary:	(507)444 - 8399	Owatonna ALC:	(507)444 - 8099
Wilson Elementary:	(507)444 - 8499		

Parent/Guardian Authorization

1. I request the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school health service office of any change in the medication (dose change, discontinuation of the medication, etc.).
4. I give permission for the school health service office to communicate with school staff about the action and side effects of this medication on a need to know basis.
5. I give permission for the school health service office to consult verbally or in written fashion with the above named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6. Field Trips: I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary following school protocol.

Parent/Guardian Signature: _____ Date: _____