MINNEHAHA ACADEMY

Annual Authorization for Administration of Medication

Student:_____ Grade:_____ Birth Date:_____ School Year:_____

Allergies:_____

Physician/licensed healthcare provider orders for administration of medication by school staff:

Medical Condition	Medication/Treatment	Dose and Route	Time/Dates Effective	Side Effects
1.				
2.				
3.				

Initial Here If: Student may self carry/administer inhaler, epi-pen, or other *emergency* medication.
____Licensed Prescriber Initials
____Parent Initials

Medication MUST be provided in the original, CURRENT manufacturer or prescription container.
Please only include/provide medications that must be given during the school day. At home administration is preferred.
Medications that are not picked up will be disposed of at the end of each school year.
All medication authorizations expire at the end of each school year.

Physician Signature:_____ Date:_____

Physician Name (print):_____ Clinic Name:_____

Phone:_____ Fax:_____

Parent/Guardian Authorization

1. I request that the above medications and/or treatments be given during school hours as ordered by my student's physician or licensed healthcare provider. I also request the medication to be given on field trips, as prescribed.
2. I will notify the school of any changes in medication(s). I will provide the school with a new, signed copy of this form to reflect those changes.
3. I give permission for the medication(s) to be given to my student by the school personnel as delegated, trained, and supervised by the school nurse. School personnel may include teachers, qualified parent volunteers, and support staff.
4. I understand that legally, I may refuse to sign for the medication. If I refuse to sign the authorization, Minnehaha Academy will not be able to administer the medication to my student at school.
5. This authorization may be revoked at any time, by sending a written notice to the school nurse.
6. By signing below I also give the school nurse permission to communicate with school staff regarding my child's medical condition and treatment.
7. I give the school nurse permission to consult with my child's physician/licensed healthcare provider regarding the above medical condition and treatment.
8. I give permission for the physician/licensed healthcare prescriber to release information related to the above medications and medical conditions to the school nurse.

Parent/Guardian Signature: _____ Relationship to Student:_____

Parent/Guardian Name (print):_____ Date:_____

Phone 1:_____ Phone 2:_____