INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number **506.2.2.1P** Adopted **December 1987** Revised **July 2020**

Title **Authorization for Administration of Prescription Medication at School**

Medication Authorization Form (ECSE – Grade 12)

Student_____ DOB_____ Grade_____ School Yr_____

School_____ Allergies_____

NOTE: Medication must be supplied in original labeled prescription bottle.
***No narcotic pain medication will be administered during the school day unless authorized by a physician.**

Medication	Controlled Substance Yes/No	ICD-10 Medical condition	Dose	Time	Route	Possible side effects
1.						
2.						
3.						

other considerations/directions_____

signature of physician/licensed prescriber | print name of physician/licensed prescriber | date

clinic name | clinic phone | clinic fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my student's physician/licensed prescriber. I also request the medication(s) be given on field trips as prescribed.
2. I will notify the school of any change in the medication(s), i.e., dosage change, medication is stopped, etc.
3. I give permission for the medication(s) to be given by trained school personnel when delegated by the school nurse in her/his absence.
4. I release school personnel from liability in the event adverse reactions result from taking the medication.
5. This consent may be revoked at any time by sending a written notice to the licensed school nurse.
6. I understand that I am required to retrieve controlled substances when requested by the school.
7. I designate the school district as an authorized entity to transport non-controlled substances for purposes of destruction if unused amounts remain in the possession of school personnel.

parent/guardian signature | date | relationship to student

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
2. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

parent/guardian signature | date | relationship to student

Return to_____ phone_____ fax_____
RN, Licensed School Nurse