

St. Francis Area Schools

Health Services
4115 Ambassador Blvd. NW, St. Francis, MN 55070
763-753-7040 | www.isd15.org

Prescription Medication Authorization Form

Date _____

Student's Name _____ Date of Birth _____ Weight _____

Grade _____ School Year _____ School _____

Medical Condition	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route	Start Date	Stop Date

(All authorizations expire at the end of the school year or at the end of Extended School Year summer school programs)

Print or Type Name of Physician/Licensed Prescriber _____

Signature of Physician/Licensed Prescriber _____

Clinic Address _____

Fax Number _____

Phone Number _____

Date _____

NOTE: Medication is to be supplied in the original/prescription bottle.

Parent I Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request that the medication(s) be given on field trips, including overnight field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking medication(s).
3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
4. I give permission for the school nurse or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
6. I give permission for the school nurse or designee to consult (in oral or written format) with the above named student's physician/ licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to physician/licensed prescriber and parent/guardian via monitoring form.

My son/daughter may self-carry and self-administer his/her asthma inhaler/EpiPen if appropriate as assessed by the Licensed School Nurse.

My son/daughter attends: Kids Connection School Sponsored Sports Extracurricular Activities

Medications are kept in the school health office, are locked and are not accessible outside of school hours.

Parent will communicate pertinent health conditions and supply necessary medications/supplies to appropriate staff/department.

Parent/Guardian Signature _____ Date _____

Relationship to Student _____ Home/Cell Phone _____ Work Phone _____

School Fax Numbers: St. Francis Elementary (763) 753-7721
Cedar Creek Elementary (763) 753-7714
St. Francis High School (763) 753-7720
Early Childhood Family Center (763) 753-7715

East Bethel Elementary (763) 753-7719;
St. Francis Middle School (763) 753-7721
St. Francis Learning Center (763) 753-7749