MEDICATION AUTHORIZATION FORM

Complete One Form per Medication

Name of Student _____ Date of Birth _____

School _____ Grade _____ Homeroom/Advisory Teacher: _____

PHYSICIAN/MEDICAL PROVIDER ORDER

I hereby request and authorize school staff to give:

Medication Name Dosage Route Time Duration

_____

Diagnosis or medical reason for medications: _____

Other medication this student is taking: _____

Potential side effects and other recommendations: _____

Medical Provider Signature: _____ Date: _____

Provider Name (Printed): _____ Phone: _____

Clinic Name & Location: _____ Fax Number: _____

PARENT / GUARDIAN AUTHORIZATION – PLEASE READ AND SIGN BELOW

1. I request that the above medication be given during school hours as ordered by this student's physician.
2. I understand ALL medication (prescription, over-the-counter, and nutritional supplements) should be in the original container clearly marked with the student's name, the medication name, the dosage to be given, the time to be given and the method of administration. Prescription medications should also include the physician's name and the pharmacy name.
3. I understand that I will give the first dose of a new medication at home to observe for any side effects.
4. I release school personnel from any liability in relation to this request when the medication is given as ordered.
5. I understand that I need to bring in a new medication authorization with all medication changes including discontinuing a medication for the time stated on the doctor's orders.
6. I give permission for the health office staff to communicate with teachers/staff about the action and side effects of this medication.
7. I give permission for the health office staff to consult with the above named physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
8. **FIELD TRIPS:** I give permission for the assigned trained staff to administer the medication on a field trip, as necessary, following school procedures.

☞ **Signature of Parent/Guardian: X_____ Date: _____**

FARIBAULT HEALTH OFFICE FAX NUMBERS

ALC	Fax: 507-333-6048	Faribault High School	Fax: 507-333-6111
Faribault Middle School	Fax: 507-333-6400	Jefferson Elementary	Fax: 507-333-6544
Lincoln Elementary	Fax: 507-333-6642	Roosevelt Elementary	Fax: 507-333-6734
McKinley/ All Early Childhood Programs	Fax: 507-333-6830		