DETROIT LAKES PUBLIC SCHOOLS

School Medication Authorization Form

Student Name: ______________________________ Date of Birth:________________ Grade:______ School year:_____________

School: ☐ Roosevelt ☐ Rossman ☐ Middle School ☐ High School ☐ ALC ☐ Lincoln Ed. Center

(218) Fax: 847-1305 Fax: 847-1481 Fax: 847-0057 Fax: 846-1797 Fax:844-6888 Fax: 847-9794

☐ **PRESCRIPTION MEDICATION:**

If prescription medications are to be given during school hours, parent/guardian is required to provide the school with the following information: **1)** Physician/Licensed Provider order **2)** Signed parent consent **3)** Medication in the ORIGINAL pharmacy labeled bottle.

☐ **NON-PRESCRIPTION MEDICATION:**

If non-prescription (over the counter) medication is to be given to your child during school hours, parent/guardian is required to provide: **1)** Signed parent consent **2)** Medication in the ORIGINAL bottle.

Order for Medication Administration by School Staff

(Only one medication per form)

Medication:	
Dose:	
Time to be given at school:	
Reason for use (medical condition):	ICD-10 code:
Other instructions/significant side effects:	

_______________________________ _______________________________ _______________

Signature of Physician/Licensed Provider Printed name Date

_______________________________ _______________________________ _______________

Clinic Phone Fax

Parent/Guardian Authorization and Release of Information

I request that my child be assisted in taking the above medication at school by trained school staff - this staff member may not always be a licensed nurse. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in physician/licensed prescriber.

I authorize the exchange of information between my child's physician/licensed prescriber, District Nurse or school administrator with regard to this medication request.

☐ **Check here** if you authorize your child to transport any remaining medication home at the end of the year. Medication not picked up by the last day of school will be disposed of according to MN Department of Health protocol.

_______________________________ _______________ _______________

Parent/Guardian Signature **Phone #** **Date**