

MEDICATION/PROCEDURE FORM (SIDE 1)

DISTRICT PROCEDURES AND MINNESOTA GUIDELINES REQUIRE THE FOLLOWING:

1. Medications which are required during school hours and which the parent/guardian is unable to come and administer, must be administered by a nurse or a designee to whom the Licensed School Nurse has trained and delegated the function of medication administration.
2. Medication to be given at school is to be supplied in the original container/prescription bottle. A bottle of the medication should be prepared by the pharmacist, for school, with the appropriate labeling for school use.
3. Written parental permission and licensed health care provider permission are both required for all prescription medication. A new authorization form must be completed annually in the fall of the year. **PARENT/GUARDIAN(S) MUST COMMUNICATE MEDICATION NEEDS WITH KIDS CLUB, IF APPROPRIATE.** *Written parental permission is required for all medications (prescription or over the counter). NOTE: No "ASPIRIN" or Aspirin containing products will be accepted for administration to students without authorization from a licensed prescribing practitioner.
4. All medication must be accompanied by specific instructions, when and how it is to be given, and for how many days.
5. All medication must be kept in a locked cabinet and administered in the health office. Special exceptions to these circumstances may be made when approved and deemed safe by the Licensed School Nurse. Examples may be self-carry, IEP, 504, or health plan related issues.
6. **UNDER NO CIRCUMSTANCES** will school personnel provide any over the counter medication to students. Schools do NOT have stock medications.
7. All medication administered must be approved by the F.D.A., unless a licensed prescribing practitioner and a Licensed School Nurse deems it medically necessary that it be administered during the school day.
8. Administration of each dose of medication shall be recorded on the student's electronic health record.
9. Health staff will not send prescription medication home with a student unless pre-arranged with a parent. Any medication remaining in the health office past the end of the school year will be properly disposed of.

This form should be completed by parent/guardian and physician/licensed prescriber, if necessary. The form should be returned to the school your child attends (faxing is acceptable).					
SCHOOL	PHONE	FAX	SCHOOL	PHONE	FAX
Armstrong	425-4102	425-4115	Cottage Grove Middle	425-6812	425-6828
Bailey	425-4802	425-4815	Lake Middle	425-6412	425-6428
Central Park	425-2711	739-1538	Oltman Middle	425-3511	425-3555
Cottage Grove Elem	425-5802	425-5815	Woodbury Middle	425-4507	425-4567
Crestview	425-3802	425-3815	SWAHS	425-7001	425-7015
Grey Cloud	425-4202	425-4215	East Ridge High	425-2304	425-2307
Hillside	425-4002	425-4015	Park High	425-3706	425-3705
Liberty Ridge	425-5902	425-5915	Woodbury High	425-4403	425-4412
Liberty Ridge Site II	425-7162	425-7165	Next Step	425-5106	425-5115
Middleton	425-4902	425-4915			
Newport	425-4302	425-4315	**Kids Club – All Sites	425-6637	425-6620
Nuevas Fronteras	425-3102	425-3115			
Pine Hill	425-3902	425-3915	DPC/ECSE	425-6162	425-6199
Pullman	425-3602	425-3615			
Red Rock	425-5602	425-5615			
Royal Oaks	425-4702	425-4715	New Life	757-4330	459-6194
Valley Crossing	425-7502	425-7515	St Ambrose	768-3014	768-3080
Woodbury Elem	425-4602	425-4615	Hope Christian Academy	459-6438	769-2108

NOTE: Medication will not be administered without proper authorization. OVER



MEDICATION/PROCEDURE FORM (SIDE 2)

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Date: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION/TREATMENT

HIPPA-Compliant Authorization for Exchange of Health and Education Information **Medications at School:**

*Prescription Medications – Requires authorization from the parent and licensed health care provider.

*Non-prescription Medication (OTC) – Requires authorization from the parent

Procedures at School:

*Bladder catheterization *blood glucose monitoring *gastrostomy feeding *oxygen administration *blood pressure monitoring on a regular basis

LICENSED HEALTH CARE PROVIDER AUTHORIZATION

Diagnosis & ICD 10	Medications/Procedure*	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					

Other considerations/directions: _____ Start Date: _____ Stop Date: _____

 PRINT NAME of Licensed Prescriber

 Signature of Licensed Prescriber

 Date

 Clinic Name/City

 Phone Number

 Fax Number

PARENT/GUARDIAN AUTHORIZATION

- The purpose of this consent form is to authorize for the safe and necessary administration of medication and treatment in school.
- Legally, you may refuse to sign, if you refuse, we will not be able to provide service.
- Information regarding this order will only be given to South Washington County School District 833 staff who need this information to support the student's education.
- The prescribing health professional may release information to and request information from South Washington County School District related to the authorized service.
- District 833 professional staff may release information to and request information from the prescribing health professional related to the authorized service.
- A photocopy/fax of this authorization that has not been altered will be treated in the same manner as the original.
- I recognize that health records, once received by District 833, may no longer be protected by HIPPA, but they will become educational records protected by the Family Educational Rights and Privacy Act (FERPA).
- I request the above medication(s) be given during school hours as ordered by the student's physician/licensed prescriber.
- I will notify the school of any change in the medication(s). Example: dosage change, medication is stopped, etc.
- I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
- The authorization expires at the end of each school year or after summer school term.
- I understand that an individual and/or an emergency care plan may be written by the school.
- I understand that communication regarding the above health condition and/or medication with parent(s)/guardian(s) as well as the health professional may be in electronic form which could include email, SMS, etc.

PLEASE CHECK ONE OF THE OPTIONS BELOW FOR RETURNING MEDICATION AT THE END OF THE YEAR. Any medications left after the last day of school will be disposed of appropriately.

_____ I will pick up all medication from the health office by the end of the last day of school.

_____ Please send home all medication in my student's backpack on the last day of school.

 Parent/Guardian Signature

 Relationship to Student

 Date