LAKES INTERNATIONAL LANGUAGE ACADEMY
An IB World School

Authorization for Administration of Medication at School

Name of Student _____ Birth Date _____
School _____ School Year _____ Grade _____

Medical Condition/ ICD 10 Code	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route

Other considerations/ directions _____
Start date _____ End date _____ (All authorizations expire at the end of the school year)

☐ Student may self-carry/ administer his/her inhaler/Epipen®/diabetic supplies, with an MD order, Parent/Guardian authorization and if appropriate as determined by the School Nurse.

_____ _____
Print or Type Name of Physician / Licensed Prescriber | Signature of Physician / Licensed Prescriber

_____ _____ _____ _____
Clinic Address | Phone Number | Fax Number | Date

Parent / 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, as prescribed and per district policy.
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 Lakes International Language Academy staff that requires this information to provide for my student's education.
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.
7. I acknowledge that any medication(s) not picked up at the end of the school year will be destroyed and that any controlled medication(s) must be dropped off and picked up by a parent/guardian.

This authorization may be revoked at any time in writing and automatically expires at the end of the school year.

NOTE: Medication is to be supplied in the original/prescription bottle and cannot be expired.
Over the counter medications must be provided in a sealed, original labeled container and cannot be expired.

☐ My son/daughter may self-carry / administer his/her inhaler/Epipen®/diabetic supplies, with an MD order and if appropriate as determined by the School Nurse.

☐ I give permission for the health office to send remaining medication (non-controlled only) home with my child at the end of the school year or if medication is discontinued sooner. Date _____ Initials_____

_____ _____ _____
Parent/Guardian Signature | Relationship to Student | Date

Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect educational outcomes or this student's safety

District Fax #: Elementary- Main Campus/ Kinder Prep 651-464-4429 Upper School- Headwaters Campus 651-464-8990