Pillager School District #116
Nurse's Office (218) 746-2062 FAX (218) 746-4236
323 East 2nd Street South, Pillager, MN 56473

Authorization for Administration of Medication at School (prescription and over-the-counter)

Name of Student: _____ Birth date:_____ Grade:_____

Allergies:_____ School Year:_____

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						
4.						

Other Considerations / Directions: _____

Start Date: _____ Stop Date:_____
(All authorizations expire at the end of the school year.)

- □ Student is knowledgeable about the medication and how to administer it.
- □ Student has the skills to safely possess and use an inhaler.
- □ Student may self-administer the medication. (Not applicable for controlled substances.)

_____ _____
Print or Type Name of Physician / Licensed Prescriber Physician's / Licensed Prescriber's Signature

_____ _____ _____
Clinic Address Phone 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 the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the 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 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 school nurse to consult 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).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

- □ My son/daughter may self-administer his/her medication. (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

_____ _____ _____
Date Parent/Guardian Signature Relationship to Student

(NOTE: All medications must be in original/prescription bottle)