PRIOR LAKE-SAVAGE AREA SCHOOLS

Prescription Medication Authorization Form

School Year _____

Student: _____ DOB: _____ Grade _____

PHYSICIAN/LICENSED PRESCRIBER – PLEASE COMPLETE FRONT SIDE

DIAGNOSIS/SIGNIFICANT FINDINGS:

HISTORY:

ALLERGIES:

MEDICATIONS REQUIRED DURING SCHOOL HOURS/PROGRAMMING

All authorizations expire at the end of the school year or summer program

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

*****Medication must be supplied in the original prescription container.*****

TREATMENTS/PROCEDURES REQUIRED DURING SCHOOL HOURS/PROGRAMMING

(i.e., peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes)

Medical Condition	Treatment/Procedure	Time (s) or Frequency	Special Instructions
1.			
2.			
3.			
4.			

Inhaler:

- ☐ Student may carry/self administer their inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ☐ It is my professional opinion that this student **should not carry** their inhaled medication.

Epi-pen (Secondary Only):

- ☐ Student may carry/self administer their Epi-Pen/auto-injector according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ☐ It is my professional opinion that this student **should not carry** their Epi-pen/auto-injector.

Other:

- ☐ Student may carry/self administer _____ (Please identify) if agreed upon by parent/guardian and school district. Not applicable for controlled substances. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

_____ _____ _____

Print Name of Physician/Licensed Prescriber | Physician's/Licensed Prescriber's Signature | Date

_____ _____ _____

Clinic Address | Clinic Phone # | Clinic Fax #

Please fax this form to my student's school nurse. Fax number:_____

Updated: January 2023

Parent/Guardian Medication Authorization

Student: _____ **Grade:** _____
Allergies: _____

1. I request that the medication(s) and/or treatment(s)/procedure(s) ordered be given / performed during school hours/programming as ordered by this student's physician/licensed prescriber. I will provide the school with physician/licensed prescriber authorization **for any change** in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)
2. I give permission for the school nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.
3. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designated personnel as delegated by the school nurse or after hours designee or for my child to carry/self-administer _____ (please identify) if authorized by my child's physician/licensed provider as indicated on the previous page and agreed upon by the school district..
4. I understand that school health personnel cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from my student's physician/licensed prescriber and without my written permission on this form
5. Only daily medications and those for life threatening/emergency conditions will be sent on field trips. The administration of medications and delegation may be different when on field trips or at after school hours activities.
6. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).
7. Elementary students will not be permitted to carry any medication or refills.I will deliver all medication directly to the school health office and Kid's company office.
8. Secondary students will not be permitted to carry any controlled medication or refills. I will deliver all controlled medication to the school health office.
9. It is my responsibility to communicate any medication needs or changes to the school district and to programming outside of the school day such as Kid's Company. All programs administering medications for my child will need a separate labeled prescription bottle.
10. If my child will be self-administering any medication, my child is knowledgeable about the medication, when and how to take it, and the quantity to take. I have read the Self-Administration of Medication Student Agreement. I understand my child is entirely responsible for the use of any self-administered medication and the use of such medication will not be monitored by the school staff.
11. If my child attends Kid's Company, I give consent for the school district to give this form with my and my child's information to Kid's Company.
12. Storage and Medication Return (Select One)
    - ☐ The administration of the drug or medication on the reverse side of this form requires the school to store the drug or medication. The drugs or medications on the reverse side of this form **are not controlled substances.** I designate the school district as an authorized entity to transport the drugs or medications for the purpose of destruction if any unused drugs or medications remain in the possession of school personnel.
    - ☐ The administration of the drug or medication on the reverse side of this form requires the school to store the drug or medication. The drugs or medications on the reverse side of this form **are controlled substances**. I understand that I am required to retrieve the drugs or controlled substances when requested by the school. Examples of Controlled Medications include opiates, stimulants, and depressants.
    - ☐ The administration of drugs or medications on the reverse side of this form does not require a school to store the drug or medication (self-administered medication).

_____	_____	_____
Date	Parent/Guardian Signature	Relationship to Student