ISD 482

Little Falls Community Schools
Prescription Medication Administration Authorization

****This authorization is only valid for the current school year****

The following are required for prescription medication administration during school hours:

1. Doctor's written order
2. Written Parent Permission/Request
3. Medication-supplied in the **original bottle**. Ask pharmacy for an additional pharmacy labeled bottle for school supply of medication.

Student's Name: _____ Date of Birth: ____/____/____
School: _____ Grade: _____
Doctor's Name: _____Clinic: _____

Parental Request for Medication Administration

1. I request the below medication(s) be given to child listed above as prescribed and the requested information to be released by the physician to the school.
2. I release all approved ISD #482 school personnel who are administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
3. I give permission for the school nurse to consult with this child's physician regarding the listed medication(s), medical condition or side effects of this medication.
4. I will immediately notify the school of any change in the mediation or physician's order, dosage change, frequency, or duration of administration.
5. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
6. Field trips: I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
7. Administration of scheduled medications will be given no more than one hour before or after physician's indicated medication time.
8. The first day's dose of any new medication must be given at home.
9. All medications must be picked up on the last day of school by a parent/guardian. Any remaining medications will be delivered to the LFPD to be disposed of lawfully.

Parent/Guardian Signature: _____ Today's Date: ___/___/___
Phone Number: _____ (H) Phone number: _____ (C)

Physician's Orders For Administration of Medication by School Personnel

1. Medication name: _____ Dose: _____
   Route: _____ Time(s) to be administered: _____Frequency_____
   For the treatment of: _____
   Potential Side Effects: _____

2. Medication name: _____ Dose: _____
   Route: _____ Time(s) to be administered: _____Frequency_____
   For the treatment of: _____
   Potential Side Effects: _____

In my judgment, this student is able to independently use their insulin, inhaler or EpiPen correctly and may independently carry it with him/her. Yes _____ No _____

Physician's Signature: _____ Date: ___/___/___

Please return completed form to your child's school nurse.