CENTENNIAL
SCHOOL DISTRICT 12

Authorization for Medication Administration

This procedure was developed to comply with the Centennial School Board Policy, Minnesota Department of Health Guidelines for Medication Administration in Schools, and MN Statute 121A.22. It is designed to protect parents/guardians, school personnel, and the health, safety and welfare of the student.

Please note:

- ☐ This form and a written order from a prescribing professional MUST be completed for ANY medication (prescription or over the counter) to be administered at school. This form and a written order from a prescribing professional must be submitted each school year **and** when there are changes to the medication, dose or administration.
- ☐ Prescription medication must come from the pharmacy in a current pharmacy-labeled container. This includes epinephrine auto injectors, inhalers and insulin pens.
- ☐ Pharmacy labels must be attached directly to epinephrine auto injectors, inhalers and insulin pens.
- ☐ Over-the-counter medication must come in the originally labeled and sealed container with the student's name written on it.
- ☐ Only 30 tablets/capsules may be submitted at one time.
- ☐ If tablets are required to be split, they must be split prior to submitting to the health office.
- ☐ All medications must be submitted by a parent/guardian, students are not allowed to transport medication.
- ☐ All medications must be picked up at the end of the school year by the parent/guardian.

If you have any questions regarding medication administration at school, please contact your students school or the district Health Services Coordinator Kelsi Gruber, RN,BSN,PHN,LSN at 763-792-5231.

To be completed by a Medical Provider:

Student's Name_____**Birth Date**_____**Today's date**_____

Diagnosis	ICD 10 Code	Medication	Dose	Time	Route	Side Effects	Discontinue Date

Other considerations/directions: _____

(All authorizations expire at the end of the school year)

_____ _____

Physician/Licensed Prescriber's NAME Physician/Licensed Prescriber's SIGNATURE DATE

_____ _____

Clinic Name and Phone Number Clinic Fax Number

Parent/Guardian Authorization for Giving Medication at School

1. I request that the above medication be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medications be given on field trips as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will provide updated medical orders if there is a change in the medication (e.g. dose change, medication is discontinued, etc.) A new medication permission form is required each school year.
4. I give permission for the school nurse to communicate with the student's teacher(s) about the action and side effects of this medication and correlating diagnosis.
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 above medication(s) or medical condition(s) being treated by the above medications.
6. I give permission for the medications to be given by designated personnel as delegated by the school nurse.
7. I will pick up any unused medication at the end of the school year.
8. I understand that medication will not be accepted unless all requirements have been met.

_____ _____

Date Parent/Guardian Signature

Building Fax Numbers:

CHS/CALC/JOURNEY: 763-392-7274
PINES: scardinal@isd12.org
CMS: 763-392-7281
BHE: 763-392-7534
CTE: 763-392-7516
CVE: 763-392-7296
GLE: 763-392-7295
RLE: 763-392-7282