School District 622
NORTH ST. PAUL | MAPLEWOOD | OAKDALE
Ready for tomorrow

Authorization for Administration of Medication at School

Name of Student:_____ Birthdate:____/____/____

School:_____ School Year: _____ Grade:_____

Phone Number: (___)_____ Fax Number: (___)_____

Medical Condition	ICD 10 Code	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.)

_____ _____

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

_____ (___)_____

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 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 action and side effects of this 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.

_____ _____ _____

Date | Parent/Guardian Signature | Relationship to Student

NOTE: Medication is to be supplied in the original/prescription bottle/container.