DETROIT LAKES PUBLIC SCHOOLS - ISD #22

School Medication Authorization Form

Student Name: ________________________________Date of Birth:________________

Grade:_____ School year:___________

✔ Medications must be provided in the **original container** or prescription bottle.
✔ Medications must have a **current expiration date**.

☐ Roosevelt Fax: 218-847-1305
☐ Rossman Fax: 218-847-1481
☐ Middle School Fax: 218-847-0057
☐ High School Fax: 218-846-1797
☐ ALC Fax: 218-:844-6888
☐ Lincoln Ed. Center Fax: 218-847-9794

☐ PRESCRIPTION medication ⟶ Licensed Prescriber completes this section
☐ OVER THE COUNTER medication ⟶ Parent/guardian completes Reason for use/Medication/Dose/Time

Reason for use (Medical Condition): ______________________________ ICD-10 code:_________________

Medication	Dose	Time	Special instructions

Name and Title of Licensed Prescriber (please print): _______________________________________

Licensed Provider's Signature: ___________________________________

Clinic: ________________________________ Location: ________________________________

Date: ____/____/________

Fax: ________________________________ Phone : ________________________________

Parent/Guardian Authorization

I give permission for the above medication(s) to be administered to my child by school staff, as described. I will provide the medication in the original container. I give school health staff permission to: 1) Communicate with the child's teacher about the health condition/action of medication, 2) Consult with the above licensed prescriber or designee regarding medication or medical condition, 3) Release information related to the above medication and/or medical condition to the licensed prescriber or designee. I will notify the school for any changes to my child's health status, medication or licensed prescriber.

☐ **Check here** to authorize your child to transport any remaining medication home at the end of the year. Medication not picked up by the last day of school will be disposed of according to MN Department of Health protocol.

____________________________________ **Parent/Guardian Signature**

______________________ **Phone #**

________________________ **Date**