Staples Motley
Independent School District No. 2170

School Nurse
Health Office
218-894-5400 ext 3163

Staples High School Building
401 Centennial Lane
Staples, MN 56479

Authorization for Dispensing Medication

To be renewed annually

Please note: Whenever possible medications should be given at home, every effort should be made to avoid school hours.

Student Name: __________________DOB: ________ School:_____________________

Parent/Guardian Printed Name: ________________________________

Phone (Home): __________ Phone (Work): _____________ Emergency Cell: _______________

Physician's Order: This section may be substituted by a copy of the doctor's prescription. Please attach a copy. I request that my patient recieve the following medications at school. (Please use a separate sheet for each medication).

Medication Name and Strength:____
Name Strength

Dosage:____________ Time(s):________________ Route:_____________________

Daily:________ As Needed:__________ Short Term_________ Indefinite_____

Purpose/Diagnosis:___________________________ ICD10 code:_______________________

Special Instructions:____

Start Date:_____________________________End Date:__________________________________

Physician's Signature:____

Physician's Printed Name:________________________________ Date:_____________________

Clinic Name: ___________________ Clinic Address: ______________________________

Clinic Phone Number: ________________ Fax Number: ___________________

Parent's Permission:

I request that my child recieve this medication as prescribed by our physician. The medication is to be furnished by me in a bottle clearly and appropriately labeled by a pharmacist.

I understand that the school district is rendering a service and does not assume any responsibility for this matter. I further understand that the school nurse or other designated person will administer the medication.

Parent/Guardian Signature:___________________________________Date:_____________________