



Buffalo Lake-Hector-Stewart High School

ISD #2159

www.blhsd.org



Prescription Medication

Medical Order for Medication and Parent/Guardian Authorization Form

(To be renewed annually)

Medications should be administered at home under the supervision of the parent/guardian whenever possible. Before any prescription medication will be given by school staff, a form signed by the physician and parent/guardian of the student must be on file with the school. Prescription medications must be provided in an original pharmacy container with a current label.

STUDENT: _____ BIRTH DATE: _____

SCHOOL: _____ GRADE: _____

PHYSICIAN/ LICENSED PRESCRIBER'S ORDER

Medication	Dosage	Frequency	Duration (One Year)

Condition for which prescribed: _____

Allergies: (food or medications) ___ Yes ___ No Please List: _____

Possible side effects: _____

This student is both capable and responsible for **self-administering** this medication (subject to school policy):
___ No ___ Yes, supervised ___ Yes, unsupervised

In the event of missed doses at home this student may take missed dose at school with parent direction. ___ YES ___ NO

Physician or Authorized Prescriber: (Please print) _____

Clinic / Address: _____ Phone #: _____

Signature: _____ Date: _____

Parent/Guardian Authorization

- I request that the above medication be given at school as prescribed by the physician / licensed prescriber.
- I give permission for the school nurse to consult with the above named students' physician/licensed prescriber regarding questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication.
- I release school personnel from any liability in the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse.
- I understand that to promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.

Physician and I agree that my child needs medication on field trips. ___ Yes ___ No

Parent / Guardian Signature: (Required) _____ Date: _____

Home Phone Number: _____ Work: _____ Cell: _____

Return this form to your school or **Renville County Public Health Fax 320-523-3749 / Attn: School Nurse**

School fax numbers: BLHS Elementary: 320-833-5312 BLHS High School: 320-848-2401



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Over-the-Counter (OTC) Medication Parent/Guardian Authorization Form (To be renewed annually)

Parent/Guardian must complete and sign a form before school staff will give over-the-counter medications. Over-the-counter medications must be provided in the original labeled container. OTC medications will only be administered to a student according to the label directions, unless contrary written directions from a physician are provided.

Students in grades 7-12 may possess and use **nonprescription pain relief** in a manner consistent with the labeling, with written authorization from the parent/guardian permitting the student to self-administer the pain relief medication. The district may revoke a student's privilege to possess and use nonprescription pain relievers if the district determines that the student is abusing the privilege. This rule does not include any other over-the-counter medication, especially those possessing ephedrine or pseudoephedrine. (M.S. 121A.222)

Students may not share prescription or over-the-counter medications with any other student(s). Appropriate disciplinary action may be taken if necessary, upon the determination by the principal or his/her designee, after investigation that a violation of this policy has taken place.

STUDENT: _____ **BIRTH DATE:** _____

SCHOOL NAME: _____ **GRADE:** _____

Parent/Guardian Authorization

Medication	Dosage	Frequency	Duration (One Year)

Reason for Use: _____
Allergies: (food or medications) ___ Yes ___ No Please List: _____

This student is in grade 7-12 and I allow student to possess and self-administer the above pain reliever. ___ Yes ___ No

This student is both capable and responsible for self-administering this medication (subject to school policy):
___ No ___ Yes, supervised ___ Yes, unsupervised

- I request that the above medication be given at school per the above protocol.
- I release school personnel from any liability in the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse.
- I understand that to promote safety for my child, medication information may be shared with school personnel working with my child and with 911 personnel, if they are called.

My child needs medication on field trips. ___ Yes ___ No

Parent / Guardian Signature: (Required) _____ **Date:** _____

Home Phone Number: _____ Work: _____ Cell: _____

Return this form to your school or Renville County Public Health Fax 320-523-3749 / Attn: School Nurse

School fax numbers: BLHS Elementary: 320-833- 5311 BLHS High School: 320-848-24