

HAWLEY PUBLIC SCHOOLS

School Medication Authorization Form

Student Name: _____ Date of Birth: _____ Grade: _____ School year: _____

School: Pre-School Center Spring Prairie Elementary High School
 Fax: 486-6516 498-2439 483-4638 483-3510

PRESCRIPTION MEDICATION:

If prescription medications are to be given during school hours, parent/guardian is required to provide the school with the following information: **1) Physician/Licensed Provider order 2) Signed parent consent 3) Medication in the ORIGINAL pharmacy labeled bottle.**

NON-PRESCRIPTION MEDICATION:

If short-term, non-prescription (over the counter) medication is to be given to your child during school hours, parent/guardian is required to provide: **1) Signed parent consent 2) Medication in the ORIGINAL bottle.**

Order for Medication Administration by School Staff *(Only one medication per form)*

Medication:	
Dose:	
Time to be given at school:	
Reason for use (medical condition):	<u>ICD-10 code:</u>
Other instructions/significant side effects:	

 Signature of Physician/Licensed Provider Printed name Date

 Clinic Phone Fax

Parent/Guardian Authorization and Release of Information

I request that my child be assisted in taking the above medication at school by trained school staff - this staff member may not always be a licensed nurse. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in physician/licensed prescriber.

I authorize the exchange of information between my child's physician/licensed prescriber, District Nurse or school administrator with regard to this medication request.

Parent/Guardian Signature **Phone #** **Date**