INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating, developing, and inspiring our students for lifelong success.

Series Number **506.2.2.1P** Adopted **December 1987** Revised **October 2024**

Title **Authorization for Administration of Medication at School**

Student_____ DOB_____ ID_____

Parent/Guardian _____ Phone _____

Medication to be administered at school _____

Medication Order

This section must be completed by the health care provider when medication is prescribed for more than two weeks OR is a controlled medication

Medication	ICD-10/Diagnosis	Dose	Time	Route
1.				
2.				
3.				

_____ _____ _____
Signature of health care provider | Print name of health care provider | Date

_____ _____ _____
Clinic name | Clinic phone | Clinic fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as prescribed by my child's health care provider.
2. I will notify the nurse of any change in the medication(s), i.e., dosage change, medication is stopped, etc.
3. I give permission for the medication(s) to be given by trained school personnel when delegated by a District 196 registered nurse.
4. I release school personnel from liability in the event adverse reactions result from taking the medication.
5. I understand that I must supply this medication in an original labeled prescription bottle.
6. I understand that I am required to retrieve controlled substances when requested by the school.
7. I designate the school district as an authorized entity to transport non-controlled substances for purposes of destruction if unused amounts remain in the possession of school personnel.
8. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the use of the medication(s).
9. I give permission for the nurse and health care provider to release information to and request information from each other related to the above medication(s) and medical condition(s). Health records, in the possession of the school district, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA), but will become education records protected by the Family Educational Rights and Privacy Act.

This authorization takes effect the day that I sign it and expires one year from the date of my signature. Legally I may refuse to sign this authorization. I understand that this authorization may be revoked at any time by sending a written notice to the nurse. If I refuse to sign, or revoke authorization, these services may not be provided at school.

_____ _____
Parent/guardian signature | Date

Office Use:

_____ _____ _____
Return to | phone | fax