Edina Public Schools
DEFINING EXCELLENCE

Student Name _____ **DOB** _____

Date _____ **School** _____

Edina Public Schools Medication Administration Authorization

For students that require medications for asthma, severe allergies, seizures, or diabetes, have the licensed provider complete a signed action plan.

To be completed by a physician/licensed prescriber					
Medication	**Dose in mg**	**Frequency/Time**	**Route**	**Medical Condition and ICD10**	**Check if controlled substance**
Physician/licensed prescriber signature:				**Date:**	
Print Name of Prescriber:				**Clinic Name:**	
Phone:				**Fax:**	

Parent/ Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the medications be given on field trips as prescribed. ☐ Yes ☐ No
3. I request that the medication be given during EPS non-school hours/days programming (ie. Kids Club/Enrichment Programs) and I am responsible for training the staff. I understand the school nurse may not be available during this time. ☐ Yes ☐ No
4. I request that medication be available to EPS staff during non-school hours/days for EPS programming. ☐ Yes ☐ No
5. I will notify the school/program if medication is stopped or changed.
6. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the school nurse.
7. Legally I may refuse to sign the authorization to administer medication form. If I refuse to sign, EPS will not be able to administer the medication.
8. This consent may be revoked at any time by sending a written notice to the licensed school nurse or program lead.
9. This permission expires at the end of the school year/prior to the first date of the next school year. A new authorization will be required to administer the medication after the first day of the new school year.
10. All medication, both prescribed and over the counter, must be sent to school in the original container or pharmacy-labeled container.
11. I understand that I am required to retrieve the drugs, medications, or controlled substances when asked by the school. If I do not timely up the drugs or medications, I designate the school district as an authorized entity to transport the drugs or medications for the purpose of destruction.

Parent/Guardian Signature_____ **Date** _____

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication/s in order to provide for my child's health and safety needs at school.
2. I give permission for a school nurse to contact my child's physician/licensed prescriber with questions about the above listed medication/s or medical condition/s being treated by medication/s.
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

Parent/Guardian Signature_____ **Date** _____

Edina Public Schools Medication Authorization Procedures

Whenever possible, the parent or guardian should make arrangements so that it is not necessary for school personnel to administer medication to a student while at school. When a medication is necessary during school hours, our intention is to insure the health and safety of your student. Thank you for your cooperation.

Each year, the following must be followed when sending any prescription or nonprescription medication to school:

1. **A completed parent/guardian signature and consent** authorizing school personnel to administer medication. Medications will NOT be administered or accepted until signed medical orders AND signed parental consent are provided to the health office.

2. **A written order from the physician** with instructions for all medications, prescription and over-the-counter. The order may be faxed to the school.

3. **The original pharmacy labeled container**. For prescription medications, the pharmacist can supply a labeled container, one for home and one for school. The pharmacy label must have the following:
    - Student full name,
    - Physician name,
    - Medication name and dosage,
    - Time and directions for administration,
    - Current date.

4. **New medication consent form is required when**:
    - The dosage or time of administration is changed
    - At the beginning of each school year
    - If discontinued medication is restarted. The parent/guardian must notify the school in writing when the medication is discontinued.

5. **Storage:** Medication to be administered at school will be stored in the Health Office. Exceptions are students who may carry an asthma inhaler or epinephrine, if they have a written doctor's order and written parental permission to do so and have demonstrated to the school nurse competency in administration.

6. **End of Year Medication Pickup and Disposal**: At the end of the school year, all medications must be picked up in the health office by the parent/guardian or responsible adult. Parent/guardians are encouraged to dispose of unwanted medications properly. More information can be found at Info can be found at MN Pollution Control Website. EPS will dispose of unclaimed medications following proper guidelines.

7. **Half Tablets:** Health Services Staff is not responsible for breaking tablets in half. When there is a physician order to give one-half of a tablet, talk with your pharmacist.

8. **Field Trips / Extended Learning:** Complete the field trip section on the Authorization for Medication Administration form. Additional consent will be necessary for overnight and extended trips. Health Services staff do not routinely accompany students on field trips and a teacher may be responsible for administration of medication.

9. **Standard Medications:** Health Services Staff will only administer medication that is listed and described in the Standard Physician's Desk Reference (PDR).

Edina Medication at School Policy