

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: 218-483-3510

☐ **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):	ICD-10 code:
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