ISD 482

Little Falls Community Schools
Prescription Medication Administration Authorization

School Year _____/____

The following are required for prescription medication administration during school hours:

1. Doctor's written order
2. Written Parent Permission/Request
3. Medication-supplied in the **original bottle**. Ask the pharmacy for an additional pharmacy labeled bottle for school supply of medication if needed.
4. Current signed Little Falls Community Schools Prescription Medication authorization form, must be updated every school year.

Student's Name:_____ Date of Birth: _____
School: _____ Grade: _____
Doctor's Name:_____Clinic: _____

Parental Authorization for Medication Administration

1. I request the below medication(s) be given to the child listed above as prescribed and the requested information to be released by the physician to the school.
2. I release all approved ISD #482 school personnel who are administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
3. I give permission for the school nurse to consult with this child's physician regarding the listed medication(s), medical condition or side effects of this medication.
4. I will immediately **notify the school health office** of any change in the mediation or physician's order, dosage change, frequency, or duration of administration.
5. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
6. Field trips: I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
7. Administration of scheduled medications will be given no more than one hour before or after physician's indicated medication time.
8. **The first day's dose of any new medication must be given at home.**
9. All medications must be picked up on the last day of school by a parent/guardian. Any remaining medications will be disposed of unless your child is attending **Summer School** and there has been discussions with your building health office staff.

Parent/Guardian Signature: _____ Today's Date: _____/_____/_____

Phone Number (Cell): _____ Phone number (Home/Work) _____

Provider's Orders For Administration of Medication by School Personnel

1. Medication name: _____ Dose: _____ Route: _____

Time(s) to be administered: _____Frequency_____ICD Code:_____

For the treatment of:_____Potential Side Effects: _____

2. Medication name: _____ Dose: _____ Route: _____

Time(s) to be administered: _____Frequency_____ICD Code:_____

For the treatment of:_____Potential Side Effects: _____

Provider please initial; In my judgment, this student is able to independently use their insulin, inhaler, EpiPen, other non-controlled medication correctly and may independently carry prescription medication with him/her. **Yes** _____ **No**_____

Provider Signature: _____ Date: _____/_____/_____

Please contact the Licensed School Nurse with questions:

Phone number: 320-616-3218 **Fax: 320-616-3210**