Phone: 507-671-1558 **Hayfield Community Schools ISD #203** **Fax: (507)477-3263**

Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medication to their student must provide written permission each school year that has been signed by parent/guardian and the student's health care provider.

Student: _____ School: _____
Birthdate: _____ Teacher: _____

PHYSICIAN/LICENSED PRESCRIBER'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL -
To be completed by physician/licensed prescriber.

Medication	Dose	Frequency or Time	Route	Medical Condition	Possible Side Effects

Physician/licensed prescriber signature (required):	Date:
Printed name of prescriber:	Clinic Name:
Phone:	Fax:

The medication must be provided in the original container with prescription label (other than over-the-counter).
Over-the-counter medication should labeled with the students name.
All medication orders expire at the end of the school year or following summer school session.

Parent/Guardian Authorization

1. I request the above medication(s) be given during the school hours as ordered by this student's physician/licensed prescriber.
2. I request the medication be given on field trips, as prescribed.
3. I will notify the school of any change in the medication(s). Example: dosage change, medication is stopped.
4. I give permission for the nurse to communicate, as needed, with school staff about the student's health condition and the actions of the medication(s).
5. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.

_____ _____ _____ _____
Parent/guardian signature | Relationship to student | Date | Daytime Phone

Authorization 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 the school nurse to contact my child's healthcare provider/ (Check 1 box) at: ☐Mayo Clinic Rochester, ☐Mayo Clinic Austin, ☐Olmsted Medical Center with questions about the above listed medications or medical condition/s.
3. I give permission for the healthcare provider at ☐Mayo Clinic Rochester, ☐Mayo Clinic Austin, ☐Olmsted Medical Center to release information related to the above medication/s and medical condition/s to the school nurse.
4. This consent may be revoked at any time by sending a written notice to the school nurse.

_____ _____
Parent/guardian signature | Date