

Medication and Treatment Authorization Form

Student: _____ DOB: _____ Allergies: _____

This section must be completed by the health care provider
Medication Required During School Hours

Medication	ICD 10 Code/Diagnosis	Dose	Route	Time	Possible Side Effects

Treatments/Procedures Required During School Hours
(e.g. catheterization, suctioning, ventilator care, dressing changes)

Treatment/Procedure	ICD 10 Code/Diagnosis	Time(s)/Frequency	Special Instruction

- Student may carry/self administer their inhaler.**
 This student uses *inhaled medication*, and has been instructed on proper use, side effects and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use as needed according to licensed prescriber's instructions.
- Student may carry/self administer their Epinephrine auto-injector.**
 This student uses an **Epinephrine auto-injector**, and has been instructed on proper use, side effects and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use as needed.

Health Care Provider Signature

 Print name of Health Care Provider

 Date

 Clinic Name

 Clinic Phone

 Clinic Fax

Parent/Guardian Authorization

1. I request that the above medication(s)/treatment(s) be given during school hours.
2. I will provide the required documentation from a licensed prescriber following the district medication policy and procedures.
3. I give my permission for the medication(s)/treatment(s) to be given by school personnel as delegated, trained and supervised by a Licensed School Nurse. I understand that a nurse may not necessarily give medication.
4. The procedure for administering medication on a field trip may be different from medication administration during the school day.
5. I will notify the school of any change in the medication(s)/treatment(s).
6. This consent may be revoked at any time by giving written or verbal notice to the school health office.
7. I give permission for ISD 194 nurses to consult with my child's physician about any questions regarding the listed medication(s) or medical condition(s) being treated.
8. I understand that the school intends to use the requested information to provide for my child's health and safety needs while at school. I may refuse to supply the requested personal information. The consequence for not providing the information may result in that my child will not be able to take medication during school hours dispensed from the health office. The information I provide will be shared only with staff in the school whose jobs require access to this information to ensure my child's safety and school success.
9. In consideration of special activity of the School District on behalf of my child, I release all school personnel and ISD 194 from any and all liability in the event of any adverse reactions resulting from the use or administration of the medicine.

Parent/Guardian Signature

 Print Name of Parent/Guardian

 Relationship to Student

 Date