South St. Paul Public Schools

South St Paul Public Schools
Medication/Procedure Form

District Procedures and Minnesota Statutes require the following:

- **Prescription medications and procedures:** require written authorization from the parent and a licensed healthcare provider; *unless the student is 18 years or older*
- **Over-the counter medications:** require written authorization from the parent only; *unless the student is 18 years or older*

- All medications must come in their original container and with a current prescription label (when applicable).
- The following medications may be self-carry with parental consent (and licensed prescriber consent, when necessary):
    - Prescription asthma inhalers
    - Epinephrine delivery systems (with prescriber consent)
    - Insulin
    - Over-the-counter pain relief (for secondary students only)
- Self-carry medications are subject to approval by a licensed nurse
- The health office does not carry stock over-the-counter medications
- New medication forms are required at the beginning of each school year and when changes are made from the original form.

Please return this form to the school your child attends.

South St Paul Secondary South St Paul CLC Phone: 651-457-9449 Fax: 651-457-9401	Kaposia Education Center Phone: 651-457-9424 Fax: 651-457-9453	Lincoln Center Elementary Phone: 651-457-9424 Fax: 651-457-9423

Note: Medication will not be administered without proper authorization.

Turn over →

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Medication/Procedure Form

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Date: _____

Authorization for the administration of medications/procedures

Prescriber signature not needed for over-the-counter (OTC) meds

Start Date: **Stop Date:**

Diagnosis & ICD 10	Medication/Procedure	Dose	Time	Route	Possible Side Effects

▢ The above medication may be self-carried and self-administered

▢ The above medication should be kept in the health office

_____ _____ _____

PRINT NAME of Licensed Prescriber | Signature of Licensed Prescriber | Date

_____ _____ _____

Clinic Name & City | Phone Number | Fax Number

Parent/Guardian Authorization

- I request this medication be given as ordered by the above licensed prescriber.
- I give my permission for the RN or LSN to contact the above licensed prescriber regarding questions/concerns related to my child's medication.
- I will notify the school of any change in the medication(s). Example: when the medication is stopped.
- The school health office may share necessary health information with school staff supporting your child.
- This authorization expires at the end of each school year or after the summer school term.

End of Year Medication

☐ I will pick up all medication from the health office by the end of the last day of school (Controlled substances MUST be picked up)

☐ Please send home all medication in my student's backpack on the last day of school (this does not apply to controlled substances)

_____ _____ _____

PRINT NAME of Parent/Guardian | Signature of Parent/Guardian | Date