

Pillager School District #116
 Elem Health Office (218) 746-2062 Secondary Health Office (218) 746-2114
 FAX (218) 746-2134
 323 East 2nd Street South, Pillager, MN 56473

Authorization for Administration of Medication at School (prescription and over-the-counter)

Name of Student: _____ Birth date: _____ Grade: _____

Allergies: _____ School Year: 2026-2027

Medical Condition/ICD-10 Code	Medication	Strength	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						
4.						

Other Considerations / Directions: _____

Start Date: _____ Stop Date: _____
 (All authorizations expire at the end of the school year.)

- Student is knowledgeable about the medication and how to administer it.
- Student has the skills to safely possess and use an inhaler.
- Student may self-administer the medication. (Not applicable for controlled substances.)

 Print or Type Name of Physician / Licensed Prescriber

 Physician's / Licensed Prescriber's Signature

 Clinic Address

 Phone Number

 Date

Parent / Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician / licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
 2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
 3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.)
 4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
 5. I give permission for the school nurse to consult with the above-named student's physician / licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
 6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
- My student may self-administer his/her medication. (Not applicable for controlled substances.)

 Date

 Parent/Guardian Signature

 Relationship to Student

(NOTE: All medications must be in original/prescription bottle)