Medication Authorization Form

Grade_____
School Yr ____

Student: _____ DOB: _____ Allergies_____

All medications and treatments require a medical order
All medications must be supplied in the original packaging or prescription container

Medication Required During School Hours						
Medical Condition	*ICD-10-CM code*	*Medication*	*Dose*	*Time*	*Route*	*Possible Side Effects*
1.						
2.						
3.						

Treatments/Procedures Required During School Hours *(e.g., blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes)*				
Medical Condition	*ICD-10-CM code*	*Treatment/Procedure*	*Time(s) /Frequency*	*Special Instruction*
1.				
2.				

☐ *Student may carry/self administer his/her 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. Prior to self-carry, the school nurse will verify proper use of the inhaler.

☐ *Student may carry/self administer his/her Epi-Pen injector.*
This student uses an **Epi-Pen**, 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.

_____ _____ _____
Physician Signature Print name of Physician Date

_____ Phone # _____ Fax # _____
Clinic Address

FAX FORM TO HEALTH SERVICES 763-745-6618

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(s) or treatments.
4. I will notify the school of any change in the medication(s)/treatment(s).
5. This consent may be revoked at any time by giving written or verbal notice to the school health office.
6. I give permission for the Licensed School Nurse to consult with my child's physician about any questions regarding the listed medication(s)/treatment(s) or medical condition(s) being treated.
7. 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(s)/receive treatment(s) 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 your child's safety and school success.

Parent/guardian signature_____ Relationship to student_____ Date_____

Licensed School Nurse signature_____ Date_____