WINONA AREA PUBLIC SCHOOLS

Student Health Services
507/494-1065 * 507/494-1067 (fax)

REQUEST FOR ADMINISTRATION OF MEDICATION/PROCEDURE DURING THE SCHOOL DAY

Student Name: _____ **Birthdate:** _____

School: _____ **Grade:** _____

Licensed Prescriber's Order

The following medication/procedure is to be administered to the student during the school day by school personnel.

Medication/Procedure: _____

Dosage/Route: _____

Time/Frequency: _____

Diagnosis: _____

Reason for Medication/Procedure: _____

School Year/Effective Date: _____

Student may carry inhaler Yes or No **carry epinephrine** Yes or No

Additional Information: _____

Prescriber's Signature: _____ **Date:** _____

Prescriber Name (printed): _____ **Phone:** _____

Parent/Guardian Request & Consent

- I request this medication/procedure be administered during the school day.
- Medication will be supplied in its **original, properly labeled prescription container**.
- All medication must be delivered to the school by a parent/guardian.
- No medication will be sent home with the child.
- The order is only valid for the current school year.
- I will notify the school in writing for any changes and obtain a new prescriber's order.
- I authorize school personnel to exchange information verbally or in writing with my child's practitioner regarding this medication or condition for which it is prescribed
- I release school district personnel from liability claims resulting from the administration of this medication as directed.

Parent/Guardian Signature: _____ **Date:** _____