

Post Falls School District #273  
School Nursing Services  
206 W. Mullan Ave, Post Falls ID 83854  
PO Box 40, Post Falls, ID 83877  
(208) 773-6976



Dear Parent or Guardian,

We strongly encourage that all medications be given at home whenever possible; yet, we understand that at times it is necessary to administer medication in the school setting. For the safety of your child as well as the general school population, we have developed the following guidelines:

- Must be completed and signed by the student's parent or guardian.
- A physician's signature on this form, or a written medical order **is required** before the medication can be administered at school.
- All medications must be transported to and from school by the parent or guardian and never sent with the student.
- Medications (prescription and over the counter) must be in their original container. The container must be labeled with the student's name, the name of the medication, the dosage, route and the time to be administered. An extra prescription bottle may be prepared for school at the pharmacy.
- If the prescription changes, a new authorization form must be provided to the school.
- All medication will be stored in the school office.
- The student is responsible for coming to the office to receive their medication.

If you have any questions, please call the Post Falls School District nursing office (208) 773-6976.

Thank you,  
Post Falls School District Nursing Services

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**POST FALLS**  
SCHOOL DISTRICT

### Authorization for Medication Administration

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

1. Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_

2. Name / Type of Medication \_\_\_\_\_

3. Dosage / Amount to be given \_\_\_\_\_

4. Route \_\_\_\_\_

5. Frequency / Times to be administered \_\_\_\_\_

6. Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

7. Possible reaction of Medication (symptoms, side effects, etc) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### Parent/Guardian Request / Approval:

I certify that I am the parent or guardian of the above-named student. I request and authorize school personnel to dispense the above-named medication in accordance with the prescription or Doctor's orders.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

- A physician's signature on this form, or a written medical order **is required** before the medication can be administered at school.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_