MENAHGA PUBLIC SCHOOL – HEALTH OFFICE
216 Aspen Ave. S.E., Menahga, MN 56464
Tel: (218) 564-4141 Fax: (218) 564-4502

Authorization for Administration of Medication

Student Name: _____ Date of Birth: _____

Parent/ Guardian: _____

Physician's Order

I have prescribed the following medication for this student and request the medication to be given during school hours to be administered by school personnel.

Medication	Dosage	Time	Duration
1.			
2.			

Diagnosis/medical reason for medication: _____ **ICD-10 Code:**_____

Other medication student is taking: _____

Recommendations/side effects: _____

Student may carry medication and self administer? _____**YES** _____**NO**

PHYSICIAN SIGNATURE: _____ **Phone #** _____

Clinic: _____ **Fax #** _____

Parent/Guardian Authorization

1. I request the above medication be given to my child during school hours as ordered by this student's physician.
2. I will immediately notify the school of any changes in the medication or the physician's orders dosage change, frequency, or duration of administration.
3. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
4. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
5. Field trips – I give permission for a teacher or designated adult to administer the medication on a field trip, as necessary, following school procedure.
6. I have instructed my child as to the reason and importance for taking this medication and have informed my child of the time the medication is to be taken.
7. I release all school personnel, I.S.D. # 821 and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

I understand I must provide this medication in a properly labeled pharmacy bottle.

In the event that your child will have some unused doses of medication left at the end of the school year, please advise the school on how you would like the medication returned by completing the following:

□ Please send the unused portion of my child's medication home with him/her at the end of the school year.

□ I will arrange to pick up the unused portion of my child's medication

I understand that I am responsible for making sure it arrives home safely.

Parent/Guardian Signature: _____

Telephone Home #:_____Date _____