Red Rock Central
PO Box 278, 509 S Birch St
Lamberton, MN 56152

Todd Lee, Superintendent
Phone 507-752-7361
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Medication Authorization Form

LAST NAME: _____FIRST NAME: _____ DATE OF BIRTH: _____ GRADE: _____

DIAGNOSIS/REASON FOR MEDICATION: _____ MEDICAL PROVIDER: _____

MEDICATION NAME: _____ ALLERGIES (FOOD OR MEDICINE): _____

DOSAGE/ROUTE: _____

TIME/FREQUENCY: _____ SIDE EFFECTS: _____

DATES COVERED BY ORDER: Begin Medication: _____ Stop Medication: _____

1. I request that the above medication be given during the school day.
2. I release school personnel from any liability in relation to this request when the medication is given as directed.
3. I authorize the prescriber and school nurse to exchange information when questions arise regarding this medication or the condition being treated by this medication.
4. I give permission for the nurse to communicate with school and support staff, as necessary, about the action and side effects of this medication.
5. I give permission for the assigned teacher/responsible adult to administer this medication on a field trip, as necessary, following school procedures.

PARENT/GUARDIAN SIGNATURE: _____ PHONE: _____ DATE: _____

MEDICAL PROVIDER AUTHORIZATION (If applicable):

Is child capable and responsible for SELF ADMNISTERING of this medication: _____ Yes _____ No

PROVIDER SIGNATURE: _____ DATE: _____ PHONE: _____ FAX: _____

RN/PHN/LSN Signature: _____ Date: _____

MEDICATION POLICY

- School district policy states, written parent authorization is needed before medication can be given. Each student will need their own form for each medication given.
- Prescription medication must be in the original bottle from the pharmacy. Provider signature required.
- Non-prescription medication must be in the original container and age appropriate for the student. No provider signature required.

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STANDING MEDICAL ORDERS
Medication Administration in the School Setting

1. **Prescription Medication**: The administration of prescription medications in the school setting will require the written permission of the student's parent and physician. The Licensed School Nurse (LSN) shall be notified to review the medication and then may delegate administration of the medication to an unlicensed assistive personnel (UAP). If the LSN has concerns regarding the medication, the prescribing physician will be consulted with prior to medication administration.

2. **Non-Prescription Medication**: The administration of over the counter medication requires written permission from the parent and authorization by the LSN to administer the medication in the school setting. The LSN will review the medication and delegate medication administration to the UAP. The LSN will verify the medication is appropriate to be given, if not the LSN may contact the parent or physician.

3. **Cough Drops**: Cough or sore throat drops may be administered within the school setting with parent permission. Students in 5th grade or above will be allowed to self-administer cough or sore throat drops unless the parent indicates this is not acceptable.

4. **Inhalers**: Students with asthma or other respiratory disorders that require an inhaler, will be allowed to self-carry their inhaler if the above requirements are met and indicated by their physician. School staff will be notified.

Note: Medication will be kept in the school office. The school district and LSN will not be responsible for students that self-administer medications without physician approval and school office notification.