



SIBLEY EAST PUBLIC SCHOOLS

HEALTH SERVICES

202 3rd Ave. N.W.

PO Box 1000 | Arlington, MN 55307

(High School)P: 507.964.2292 | F: 507.964.8245

(Elem)P: 507.237.3317 | F: 507.237.3300

CONSENT FORM FOR ADMINISTRATION OF PRESCRIPTION MEDICATION DURING THE SCHOOL DAY

Student Name _____ Birth Date _____

School _____ Grade _____ Teacher _____ School Year _____

PHYSICIAN/LICENSED PROVIDER ORDER

MEDICATION _____ DOSE _____ ROUTE _____

Time/Instructions to be given at school _____

Possible side effects _____

Diagnosis/medical reason for medication _____ ICD 10 code _____

****Inhalers/Epinephrine auto-injectors for 7th grade and older****

Student has received instruction and permission to self-carry and independently self-manage.

YES

NO

If inhaler: _____ with spacer _____ without spacer

LICENSED PROVIDER SIGNATURE _____ DATE _____

PRINT PROVIDER NAME _____ PHONE # _____

CLINIC _____ FAX # _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my student during the school day by designated personnel as delegated, trained, and supervised by the Licensed School Nurse and ordered by the licensed provider.
2. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of prescribed medication at school.
3. I will provide this medication in the original, properly labeled container.
4. I will notify the school if there are any medication changes and a new signed medication order will be required. Each signed medication order is only valid for the current school year.
5. I release school personnel from any liability in the event that any reaction results from the administration of this medication.
6. I authorize the Licensed School Nurse/designee to exchange information with my student's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

HEALTH OFFICE STAFF RECEIVING MEDICATION _____ DATE _____

DISTRICT NURSE SIGNATURE _____ DATE _____