WABASHA-KELLOGG SCHOOLS MEDICATION / TREATMENT PRACTITIONER ORDER & PARENT AUTHORIZATION FORM

Name: _____ **Birthdate:** _____

School: Wabasha-Kellogg High School _____ **Grade:** _____

PRACTITIONER'S ORDER

I hereby request and authorize you to give:

	Medication/Treatment	Dosage	Time	Duration
1.				
2.				
3.				

Allergies: _____

Diagnosis/medical reason for medication: _____

Other medications this student is taking: _____

Other recommendations/UNUSUAL side effects: _____

_____

Practitioner's Signature: _____ **Today's Date:** _____

Print Practitioner's Name: _____ **Phone:** _____

Clinic Name & Address: _____ **FAX:** _____

PARENT/GUARDIAN AUTHORIZATION

1. **I request that the above medication be given during school hours as ordered by this student's physician.**
2. **I release school personnel from any liability in relation to this request when the medication is given as ordered.**
3. **We will notify the school of any change in the medication (dosage change; medication is discontinued before the time stated in the doctor's order).**
4. **I give permission for the school nurse to communicate with teachers about the action and side effects of this medication.**
5. **I give permission for the school nurse to consult with the above-named student's practitioner (or acting practitioner, if absent) regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.**
6. **Field Trips: I give permission for the assigned teacher/responsible adult to dispense the medication on a field trip, as necessary, following school procedure.**

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

Relationship to Student: _____ **Daytime Phone:** _____

*****School Fax: 651-565-2769*****