Permission Form for Medication in McLeod County Schools

This form must be used for each school aged child and renewed annually

School: ☐ Glencoe-Silver Lake ☐ McLeod West ☐ Lester Prairie
☐ Hutchinson ☐ Winsted/Howard Lake/Waverly

Student:_____ Date of Birth/Age:_____

Grade:_____ Teacher/Classroom:_____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication:_____

Name of medication:_____

Instructions (schedule and dose to be given at school):_____

_____

Start date:_____ Stop date:_____

☐ For episodic/emergency events only

Restictions and/or side important side effects: ☐ None anticipated ☐ Medication allergies

☐ Yes, please describe:_____

☐ RE: GLUCOSE MONITORING
I am requesting that glucose monitoring be done during school hours. Time of monitoring:_____
Instructions for monitoring:_____
This student is both capable and responsible for self glucose monitoring in the health office:
☐ No ☐ Yes, supervised

☐ RE: INHALERS/EPI-PENS This student may carry his/her inhaler/epi-pen: ☐ No ☐ Yes
Physician assessment indicates this student has the knowledge and skills to safely self administer and possess an inhaler at school: ☐ No ☐ Yes, supervised ☐ Yes-Unsupervised

_____
Physician Signature Date

_____
Physician's Name (please print)

Clinic:_____ Phone Number:_____

I request this medication be given as prescribed and give permission for the school and physician to exchange information regarding this medication and the diagnosis for which it is prescribed. I release school personnel from liability in the event of adverse reactions resulting from taking medication(s).

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (child's name) _____

to receive the above medication at school according to standard school policy. I give my permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medications(s).

(All schools require parent/guardians to supply the medication in its original container.)

_____
Signature Date

Relationship to child:_____

Date form received by the school and initial:_____

ADMINISTRATION OF THE MEDICATION WILL NOT NECESSARILY BE DONE BY A SCHOOL NURSE.