# *LAKE CITY PUBLIC SCHOOL MEDICATION AUTHORIZATION FORM*

***Includes physician and/or parent authorization***

*Johanna Majerus, Licensed School Nurse*

*Lincoln High School 651-345-4553 (M-W)* *Bluff View Elementary 651-345-4551 (T-TH-F)*

**Student's Name:** _________________________________ **Birthdate:** ____________________

**School:** ________________________________________ **Grade/Teacher:** _______________

**Physician's Order**

I hearby request and authorize you to give:

Medication Dosage Time Duration

(Current School Year if not specified)

1). ______________________________________________________________________

2). ______________________________________________________________________

3). ______________________________________________________________________

Allergies: ______________________________________________________________

Diagnosis/reason for medication: ________________________________________

Unusual side effects/Other recommendations: ______________________________

Other medications student is taking: _____________________________________

**Physician's Signature** __________________________________ **Date** _______________

**Print Physician'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, or over-the-counter medications be given as ordered by parent.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school of any change in the medication (dosage change; medication discontinued before the time stated in the above order).
4. I give permission for the school nurse or designee to communicate with teachers about the action and side effects of this medication.
5. I give permission for the school nurse or designee to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6. I give permission for the school nurse or designee to obtain a physician's order for the above-named medication if needed and not completed by me.
7. Field trips-I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following district procedure.

**Signature of Parent/Guardian** _________________________________ **Date** _____________

**Relationship to Student** ______________________________ **Daytime Phone** ____________

*****For Health Office Use Only***** Rec'd Date ___________ Entered into SNAP **Yes No**

Reviewed/ready to file (LSN/RN initial) _____________

For Long Term Scheduled Medications Please Obtain Baseline and document in electronic record

Date ____ Height/ Weight _____ Blood Pressure _____ Pulse _______Respiratory Rate ______ Noted side effects __

*****Verbal authorization record on back******