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-F) Bluff View Elementary 651-345-4551 (T-Th)

SCHOOL MEDICATION PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM
SELF ADMINISTRATION

When a prescribing health professional, parent/guardian, student and school nurse agree that self administration of medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school. The school nurse will review the administration technique, dosage, appropriate storage and when to report concerns with the student. Orders much be renewed annually or whenever medication, dosage or administration changes.

Student Name: _____ Birth date: _____
School: _____ Grade/Teacher: _____

Physician's Order

I hear by request and authorize you to give:

Medication	Dosage	Time	Duration
1).			
2).			
3).			

Allergies: _____

Diagnosis/reason for medication: _____

Unusual side effects/Other recommendations:

_____

Other medications student is taking: _____

I understand the student, my patient, will carry this medication at school. I also understand this student, my patient, will be entirely responsible for the use of this medication and use of this medication will not be monitored by school personnel.

Physician's Signature _____ Date _____

Print Physician's Name _____ Phone _____

PARENT/GUARDIAN AUTHORIZATION

I hear by give permission for my child to self-administer medication at school as prescribed by my child's physician, and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health professional. I understand my child will carry this medication at school. I also understand my child is entirely responsible for the use of this medication. I understand use of this medication will not be monitored by school personnel. I understand my child will maintain a current supply of medication (no more than 2 days dosage for OTC non-prescription medications) easily accessible to he/she as indicated by location on the back of this form.

I release all school personnel and ISD 813 from any and all liability in the event any adverse reactions result from the use or administration of this medication or its unavailability if not kept in location indicated on the back of this form. I hold all school personnel and ISD 813 harmless from any liability resulting from allowing my child to self-administer medications during school hours.

I give permission for the school nurse/designee to obtain a physician's order for the above named medication if needed and not completed by me.

_____

Signature of Parent/Guardian Date

verbal authorization on back