

# MEDICATION AUTHORIZATION FORM

WABASSO PUBLIC SCHOOL HEALTH OFFICE

1333 MAY ST.

PO BOX 69

WABASSO, MN 56293

PHONE: 507-342-5114

FAX: 507-342-5203

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

DIAGNOSIS (reason for medication): \_\_\_\_\_ MEDICAL PROVIDER: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ ALLERGIES (FOODS OR MEDICINES):

DOSAGE/ROUTE: \_\_\_\_\_ ☐ NO

TIME/FREQUENCY: \_\_\_\_\_ ☐ YES & List: \_\_\_\_\_

DATES COVERED BY ORDER: Begin medication \_\_\_\_\_ Stop medication: \_\_\_\_\_

1. I request that the above medication be given during the school day.
2. I release school personnel from any liability in relation to this request when the medication is given as directed above.
3. I authorize the prescriber and school nurse to exchange information when questions arise with regard to this medication or the condition being treated by this medication.
4. I give permission for the nurse to communicate with school & support staff, as necessary, about the action and side effects of this medication.
5. I give permission for the assigned teacher/responsible adult to administer this medication on a field trip, as necessary, following school procedure.

\*PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE (Home) \_\_\_\_\_

(Cell) \_\_\_\_\_

(Work) \_\_\_\_\_

## MEDICAL PROVIDER AUTHORIZATION (If applicable):

Please ✓ if student is both capable & responsible for SELF-ADMINISTERING this medication: (subject to school policy)

☐ No

☐ Yes

\*MD/PA/NP SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

## MEDICATION POLICY

- School District policy states that medication may not be given to a student unless a written request from the parent is received. Each student will need their own form for each medication to be given.
- Prescription medication must be in a properly labeled bottle including the student's name, physician and name, dose and route of the medication to be given.
- Non-Prescription medication must be in the original labeled bottle & age appropriate for student. No physician signature is required unless there are indications to do so.

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