Edgerton District 581 Schools

423 1st Avenue West Edgerton, MN 56128

Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission every school year that has been signed by parent/guardian **and** the child's health care provider.

Student: _____ BD: _____ ID#: _____

School: _____ School year: _____ Grade/Rm: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Physician/licensed prescriber's order for Administration of Medication by School Personnel

NEW 2015-16 School Year: Medical Diagnosis & ICD-10-CM Code MUST be completed by Physician/Licensed Prescriber

Medical Diagnosis	ICD-10-CM Code	Medication	Dose	Time	Route	Possible Side Effects
1.						
2.						

Other considerations/directions: _____

Start date: _____ Stop date: _____

(All authorizations expire at the end of the school year or following the summer school session.)

_____ _____ _____

Signature of Physician/Licensed Prescriber | Print name of Physician/Licensed Prescriber | Date

_____ _____ _____

Clinic address | Phone | Fax

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the medication(s), (i.e., dosage change, medication is stopped, etc.).
3. I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: Medication must be supplied in original/prescription bottle.

Permission for Release of Information

6. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
8. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

_____ _____ _____

Parent/Guardian Signature | Date | Relationship to Student

Return to: _____ Phone: _____ Fax: _____

RN, Licensed School Nurse