

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
(To Be Renewed Annually)

PRESCRIPTION MEDICATION REQUIRES A PHYSICIAN'S SIGNATURE.

Student _____ Date of Birth _____

School _____ Teacher/Grade _____

Parent/Guardian Name _____

Phone Numbers: Home _____ Work _____

I hereby request and authorize you to administer to the above-named student:

	Medication	Dosage	Time	Duration	Prescription	Self-administer
1.	_____	_____	_____	_____	Yes/No	Yes/No
2.	_____	_____	_____	_____	Yes/No	Yes/No
3.	_____	_____	_____	_____	Yes/No	Yes/No

Diagnosis/medical reason for medication _____

Restrictions and/or Side Effects _____

Required for Prescription Medications and Over-the-Counter Medications that exceed package recommendations:

Physician's signature _____ Date _____

Print physician's name _____ Phone No. _____

Clinic _____ Fax No. _____

For Insulin, Epi-pens, inhalers & nebulizers ONLY: I have assessed this student and found him/her to be both capable and responsible for **SELF-ADMINISTERING/SELF CARRYING** this medication. (The school district is not responsible for missed doses of medication): () not applicable, () no, () yes, with supervision, () yes, unsupervised – may carry on person during school hours. Parents and student need to complete an "Authorization for Self-Administration of Medication" form also.

PARENT/GUARDIAN AUTHORIZATION FOR STAFF ADMINISTRATION

1. I request that the above medication(s) be given to my student during school hours.
2. I will immediately notify the school of any change in the medication or physician's order, dosage change, frequency, or duration of administration.
3. I give permission for the school nurse to consult with this student's physician concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.

Parent(s)/Guardian(s) Signature

Date

4. Field Trips – I give permission for school personnel to administer the medication(s) on a field trip, as necessary, following school procedure.

Parent(s)/Guardian(s) Signature

Date

I give my permission for my child's medical office to fax this form to my child's school. () Yes () No

Brewster Elementary School – Fax 1-507-842-5365

Round Lake High School – Fax 1-507-945-8124

For Self-Administration of Medications

For Insulin, Epi-pen, inhalers & nebulizers: This form needs to accompany a physician's authorization on the "Authorization for Administration of Medication" form, which can be found in the Student Handbook or school website (www.rlb.mntm.org).

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

I/we hereby authorize my student to self-administer the above-named medication(s) during school hours. I/we have read the student agreement below.

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

Parent(s)/Guardian(s) Signature

Date

Please refer to: Administering Medication in School Procedure

SELF-ADMINISTRATION OF MEDICATION – STUDENT AGREEMENT

Inhaler Over-The-Counter (OTC) Other: _____
(7-12 Graders can only self carry Tylenol & ibuprofen)

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or health office personnel if the following occurs:
 - My symptoms continue or get worse after taking the medication
 - My symptoms reoccur within 2-3 hours after taking my medication
 - I suspect that I am experiencing side effects from my medication
 - If I have any symptoms of an allergic reaction

Student Signature

Date