For Office Use Only: LSN ______ EMR _______

Authorization of Medication Administration at School

Parent/guardian AND a licensed health care professional must provide written permission for school personnel to administer all prescription AND over the counter medication(s) every school year.

Form Instructions: **Page 1 should be completed by a licensed healthcare provider.**
Page 2 should be completed by parent/guardian.

School Year: ______________

Student: ____ DOB: _______________ Grade: _________

Licensed Health Care Provider

Order(s) for Administration of Medication by School Personnel-

Diagnosis	Medication	Dose	Time	Route	Possible Side Effects

☐ **Student may self-carry and self-administer epipen or inhaler**

Authorization expires at the end of the current school year.

___________________________________ ____________________________________ _________
Licensed Health Care Provider Signature Printed Name of Provider Date

___________________________________ ________________________ _______________________
Clinic Name Phone Fax

CLINICS:
FAX ASTHMA & ANAPHYLAXIS ACTION PLANS TO THE SCHOOL NURSE AT 763-416-3682

FORM CONTINUES ON OTHER SIDE - PLEASE COMPLETE BOTH SIDES

Authorization of Administration of Medication at School

Parent/Guardian Authorization for Medication Administration in School

1. I request the medication(s) listed on Page 1 be given during school hours as ordered by this student's provider.
2. I request the medication(s) be given on field trips as prescribed: ☐ Yes ☐ No
3. I will immediately notify the health office of any medication change(s) (e.g. medication discontinued, dosage change, etc.)
4. I give permission for the health office staff to communicate as needed with school staff about this student's health condition(s) and the action of the medication(s).
5. I give permission for health office staff to consult with this student's licensed health care provider about any medication questions and/or any medical condition(s) being treated by the medication(s).
6. I give permission for school personnel to give the medication(s) as delegated, trained, and supervised by the Licensed School Nurse (LSN).
7. I will supply all prescription medication in the original prescription/bottle.
   I will supply any over the counter medication in an unopened tamper proof packaging.
8. I understand that all prescription and over-the-counter medication must be dropped off by parent/guardian and should not be sent with the student to school.
9. I understand that all medications not picked up by the last day of school by a parent/guardian will be discarded as pharmaceutical waste.

______________________________ ______________________________

Parent/Guardian Signature Date

__________ ______________________________

Relationship to Student Daytime Phone

FORM CONTINUES ON OTHER SIDE - PLEASE COMPLETE BOTH SIDES