PRIOR LAKE-SAVAGE AREA SCHOOLS

Medication Authorization Form

School Year _____

Student: _____ DOB: _____ Grade _____

PHYSICIAN/LICENSED PRESCRIBER –PLEASE COMPLETE

DIAGNOSIS/SIGNIFICANT FINDINGS:

HISTORY:

ALLERGIES:

MEDICATIONS REQUIRED DURING SCHOOL HOURS

All authorizations expire at the end of the school year or following Extended Year Summer session (Sp.Ed)

Medical Condition	Medication	Strength	Time	Route	Possible Side Effects
1.					
2.					
3.					
4.					

*****Medication is to be supplied in the original/prescription container.*****

TREATMENTS/PROCEDURES REQUIRED DURING SCHOOL HOURS

(i.e., peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes)

Medical Condition	Treatment/Procedure	Time(s)/Frequency	Special Instruction
1.			
2.			
3.			

Inhaler:

- ☐ Student may carry/self administer his/her inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ☐ It is my professional opinion that this student **should not carry** his/her inhaled medication.

Epi-pen:

- ☐ Student may carry/self administer his/her Epi-Pen/auto-injector according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ☐ It is my professional opinion that this student **should not carry** his/her Epi-pen/auto-injector.

Other:

- ☐ Student may carry/self administer _____ (Please identify).

_____ _____ _____

Print Name of Physician/Licensed Prescriber | Physician's/Licensed Prescriber's Signature | Date

_____ _____ _____

Clinic Address | Clinic Phone # | Clinic Fax #

Please fax this form to my student's school nurse. Fax number:_____

(Parent/Guardian Authorization on Reverse Side)

PRIOR LAKE-SAVAGE AREA SCHOOLS

Parent/Guardian Medication Authorization

Student: _____ DOB: _____
Grade: ____ Allergies: _____
(if not provided by licensed prescriber)

1. I request that the medication(s) and/or treatment(s)/procedure(s) ordered be given / performed during school hours as ordered by this student's physician/licensed prescriber.

2. I will provide the school with physician/licensed prescriber authorization **for any change** in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)

3. I give permission for the school nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.

4. I give permission for the school nurse to communicate as needed with school staff about my student's health condition(s) and the action of the medication(s) and/or treatment(s)/procedure(s).

5. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designated personnel as delegated by the school nurse.

6. I understand that school health personnel cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from my student's physician/licensed prescriber.

7. Only daily medications and those for life threatening/emergency conditions will be sent on field trips. The administration of medications and delegation may be different than when on field trips.

8. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).

_____ _____ _____
Date Parent/Guardian Signature Relationship to Student

Parent Phone Numbers: _____ _____

Self-Administration of Medication Student Agreement

I, _____ agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Maintain a written record of my medication administration at school (form, assignment notebook)
- Not allow anyone else to use my medication.
- Keep a current supply of my medication located: _____.
- I will make sure I have my medication available for field trips or other off-site school events.
- Notify the school nurse or health support of any of the following circumstances:
  _____My symptoms continue or get worse after taking my medication
  _____I suspect that I have side effects from my medication
  _____I need my medication more frequently than ordered (i.e., inhaler more than every 4 hours).

_____ **Locker #** _____ **Room #** _____
Signature of Student **Date**

The student has demonstrated knowledge about and proper use of his/her medication:

_____
Signature of Health Office Staff **Date**

5/16/12ac