



Authorization for Administration of Medication at School

Name of Student _____ Birth date _____
School _____ School year _____ Grade _____

Medical Condition/ ICD 10 Code	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route

Other considerations/ directions _____
Start date _____ End date _____ (All authorizations expire at the end of the school year)

Student may **self-carry/ administer** his/her **inhaler/Epipen®/diabetic supplies**, with an MD order, Parent/Guardian authorization and if appropriate as determined by the School Nurse.

Print or Type Name of Physician / Licensed Prescriber

Signature of Physician / Licensed Prescriber

Clinic Address

Phone Number

Fax Number

Date

Parent / Guardian Authorization

- I request that the above medication(s) be given during school hours as ordered by this student's physician/ licensed prescriber. I also request that the medication(s) be given on field trips, as prescribed and per district policy.
- I release school personnel from liability in the event adverse reactions result from taking medication(s).
- I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
- I give permission for the school nurse or designee to communicate with the Lakes International Language Academy staff that requires this information to provide for my student's education.
- I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
- I give permission for the school nurse or designee to consult (in oral or written format) with the above named student's physician/ licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to physician/ licensed prescriber and parent/ guardian via monitoring form.**
- I acknowledge that any medication(s) not picked up at the end of the school year will be destroyed and that **any controlled medication(s) must be dropped off and picked up by a parent/ guardian.**

This authorization may be revoked at any time in writing and automatically expires at the end of the school year.

NOTE: Medication is to be supplied in the original/prescription bottle and cannot be expired.

Over the counter medications must be provided in a sealed, original labeled container and cannot be expired.

My son/ daughter may **self-carry / administer** his/her **inhaler/Epipen®/diabetic supplies**, with an MD order and if appropriate as determined by the School Nurse.

I give permission for the health office to send remaining medication (non-controlled only) home with my child at the end of the school year or if medication is discontinued sooner. Date _____ Initials _____

Parent/Guardian Signature

Relationship to Student

Date

Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect educational outcomes or this student's safety.



Whenever possible, parent(s)/ guardian(s) are encouraged to give their children medication outside of school hours.

Prescription medications may only be given with written permission from the physician and the parent/guardian. Written permission must include the following:

- Name of student
- Medical condition
- Name of medication, strength, dosage, time/frequency and duration of treatment

The medication must be provided in the prescription bottle with proper labeling for school use. The labeled bottle may only contain the medication that is indicated, changes in prescription strength or timing will require updated paperwork as well as a properly labeled prescription bottle.

The parent(s) /guardian(s) who request and authorize the designated school personnel to give the medication in the dosage so prescribed by the physician, thereby release school personnel from liability should reactions result from the medication.

Controlled prescription medication should only be transported by parent/guardian and not by students.

Non-prescription medications may be given long term with written permission from the physician and parent/guardian. Written permission must include the following:

- Name of student
- Medical condition
- Name of medication, strength, dosage, time/frequency and duration of treatment

Non-prescription medication may be given short term, up to 10 days, with written permission from the parent/guardian. Written permission must include the following:

- Name of student
- Medical condition
- Name of medication, strength, dosage, time/frequency and duration of treatment

Non-prescription medications must in in their original, unopened container and be labeled with the students name and dosage.

The school has the authority to reject a request to administer non-prescription medications.

(UPPER SCHOOL ONLY)

Non-prescription PAIN medication may be self-administered with completion of the Self Administration of Non-prescription Pain Medication form by parent/guardian. This form must be completed at least once per school year and states that a parent/guardian has declared the child knowledgeable about the use of the medication and school policies and guidelines.

Written permission must include the following:

- Name of student
- School year
- Purpose of medication