

INDEPENDENT SCHOOL DISTRICT 196
 Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 506.2.2.1P Adopted December 1987 Revised July 2012

Title Authorization for Administration of Prescription Medication at School

Medication Authorization Form (ECSE – Grade 12)

Student _____ DOB _____ Grade _____ School Yr _____

School _____ Allergies _____

NOTE: Medication must be supplied in original labeled prescription bottle. *No narcotic pain medication will be administered during the school day unless authorized by a physician.					
Medication	Medical condition	Dose	Time	Route	Possible side effects
1.					
2.					
3.					

other considerations/directions _____

 signature of physician/licensed prescriber print name of physician/licensed prescriber date

 clinic name clinic phone clinic fax

Parent/Guardian Authorization		
1. I request that the above medication(s) be given during school hours as ordered by my student'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 trained school personnel when delegated by the school nurse in her/his absence. 4. I release school personnel from liability in the event adverse reactions result from taking the medication. 5. This consent may be revoked at any time by sending a written notice to the licensed school nurse.		
_____ parent/guardian signature	_____ date	_____ relationship to student
Permission for Release of Information		
1. 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). 2. 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). 3. 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		