MORRIS AREA SCHOOL DISTRICT
MORRIS, MN 56267
SCHOOL YEAR **2017-2018**

ELEMENTARY FAX 320-589-3920
HIGH SCHOOL FAX 320-589-3203
ST. MARY'S FAX 320-589-1703

Authorization for Administration of NON-Prescription Medication at School

Name of Student: _____ Birth date: _____

School: _____ Grade: _____

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

Other Considerations/Directions: _____
Start Date: _____ Stop Date: _____ (All authorizations expire at the end of the school year.)

Parent / Guardian Authorization

3. I request that the above medication(s) be given during schools hours.
4. I understand that all medications used in school are to be kept in a secured location by the school nurse.
5. I understand that dosages to be given will not be greater than listed on the bottle label unless accompanied by a physician / licensed prescriber order.
6. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
7. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and action of the medication(s).
8. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ _____ _____
Date Parent/guardian Signature Relationship to Student

Medications must be supplied in the original bottle or package.

Dosages different than listed on the bottle/package will need an authorization signed by a doctor (see other side of this form.)

Date medication received _____
Amount of medication received _____
Received by _____