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 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.)

Please complete:
Student is knowledgeable about the medication and how to administer it. Yes / No
Student has the skills to safely possess and use the inhaler and/or Epi-pen. Yes / No
(The school nurse will also assess the student's ability to self-administer medication.)

_____ _____
Print name of Physician / Licensed Prescriber **Signature of Physician / Licensed Prescriber**

_____ _____ _____
Clinic Address Phone Number Date

*Prescriber: Please remind parent to get a labeled bottle from the pharmacy for school use.

Parent / Guardian Authorization

1. I request that the above medication(s) be given during schools hours as ordered by this student's physician / licensed prescriber. I also request the medication(s) be given on field trips as prescribed.
1. I understand that all medications used in school are to be kept in a secured location by the school nurse, with the exception of approved self-administered inhalers and Epi-pens.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
2. I will notify the school of a change in the medication, i.e. dose change, discontinued, etc. Changes must be accompanied by the physician / licensed prescriber order.
3. 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).
4. I give permission for the school nurse to consult 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).
5. 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

All prescription medications must have a current prescription label--this includes oral, inhaled, Injected, and topical prescription medications. *Ask your pharmacist for an extra container for school.

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