New York Mills Public School – ISD #553

209 Hayes Avenue | New York Mills, MN 56567
Phone 218-385-2553 | Fax 218-385-2551

Authorization for Administration Prescription Medication

Student Name: _____ Date of Birth: _____

Parent/Guardian:_____ Grade_____

Physician's Order

I have prescribed the following medication for this student and request the medication to be given during school hours to be administered by the School Nurse or school personnel that have been delegated to administer meds.

MEDICATION	DOSAGE	TIME	DURATION

1. _____

2. _____

Diagnosis/medical reason for medication: _____

Other medication student is taking: _____

Recommendations/side effects: _____

Allergies:_____

PHYSICIAN SIGNATURE: _____Phone #_____

Clinic: _____ Fax # _____

Parent/Guardian Authorization

1. I request the above medication be given to my child during school hours as ordered by this student's physician.
2. I will immediately notify the school of any changes in the medication or the physician's orders dosage change, frequency, or duration of administration.
3. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
4. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
5. Field trips – I give permission for a teacher or designated adult to administer the medication on a field trip, as necessary, following school procedure.
6. I have instructed my child as to the reason and importance for taking this medication and have informed my child of the time the medication is to be taken.
7. I release all school personnel, I.S.D. #553 and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
8. ☐ I give my child permission to self-administer the medication above (Inhalers,/Epi-pens/ insulin only)
   Initials

I understand I must provide this medication in a properly labeled pharmacy bottle.

PARENT/GUARDIAN: _____

Telephone Number: _____ Date: _____