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 **April 2015**

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 | ICD-10/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