EDEN VALLEY – WATKINS ISD # 463

School Nurse (320) 453-2900, ext 2135

Elem Fax (320) 453-6457 HS Fax (320) 453-5600

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Parents of students requesting that prescription medication is administered during school hours by school staff are required to provide the following to school:

1. Physicians order (middle section of form)
2. Parental release (bottom section of form)
3. Prescription medication needs to be supplied in the ORIGINAL bottle. Ask for the prescription medication to be divided in two bottles completely labeled--one for home and one for school.

Student's Name: _____ Birth date: _____

Home Address: _____ Grade: _____ Homeroom: _____

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION AT SCHOOL

I have prescribed the following medication for this student and request the dosages to be given during school hours.

Medication name: _____Dose: _____ Time: _____

Diagnosis / Reason for medication: _____ICD-10-CM Code: _____

Possible side effects: _____Special instructions: _____

Last date to be given (this authorization expires at the end of the current school year): _____

Student may carry and self-administering an inhaler or an Epi Pen: NA: _____ No: _____ Yes_____

Physician's signature_____ Date_____

Print Physician's name: _____ Phone #: _____

Clinic name: _____ Fax #: _____

PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION

I request this medication to be given as prescribed during school hours and I understand I must provide the medication in the original pharmacy labeled bottle. I release school staff from liability in the event of reactions resulting from the administration of this medication at school. I authorize the school nurse to release information to and/or obtain information from the health care provider for the purpose of administering and monitoring effects of this medication at school. I also understand that my child's teacher or other designated staff may be consulted in regard to this diagnosis or medication usage to assure my child's safety. I understand that this medication will not necessarily be administered by the school nurse; alternate staff will have medication administration training.

Parent/Guardian Signature: _____ Date: _____

Day/Cell phone #: _____

*This order expires at the end of the current school year. Rev 2/2023