



**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

Parents/guardians asking school staff to give medications to their child must provide (written) permission from themselves and the health care provider every school year.

Student: \_\_\_\_\_ Birth date: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ School year: \_\_\_\_\_

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects

**NOTE: MEDICATION MUST BE SUPPLIED IN THE ORIGINAL PRESCRIPTION BOTTLE**

Start date: \_\_\_\_\_ Stop date: \_\_\_\_\_

(Authorization expires at the end of the school year or following the summer session)

\_\_\_\_\_  
Signature of Physician/Licensed Prescriber

\_\_\_\_\_  
Print name of Physician/Licensed Prescriber

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

**Parent/Guardian Authorization**

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request that the medication 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 school nurse to communicate as needed with school staff about my child's health condition(s) and the action of the medication(s).
4. 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 the medication(s.)

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to student

**Return to: IHMCS school office – FAX 952-935-2031**

*For questions, contact Pat Boyd, school nurse at 952.988.4332*