MEDICATION AUTHORIZATION

Student Name **Student ID** **DOB** **Grade** **School**

Parent/Guardian Name #1 Phone Number

Parent/Guardian Name #2 Phone Number

ADMINISTRATION OF MEDICATION AT SCHOOL REQUIRES:

- The licensed prescriber's order (MD, PA, CNP, DDS) for prescription medication and for over-the-counter medication at doses that exceed the recommended dose on the label.
- Prescribed medication must be in a pharmacy labelled container. (The pharmacy can provide the medication to you in a bottle for school and a separate bottle for home.) Over-the-counter medication must be supplied in the original container and not expired
- Provider orders are effective throughout the current school year, summer school and through September 30th of the following school year unless the orders are discontinued or changed by the provider or withdrawn in writing by the parent before that time elapses.

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION:

☐ I request that authorized persons at my child's school assist my child in taking prescribed medication(s) as ordered by his/her licensed prescriber, and/or in taking over-the-counter medication per the manufacturer's recommendation.

☐ I confirm that my child has previously taken this medication.

☐ I request that my child be allowed to self-carry and self-administer emergency medication that may be necessary to treat health conditions. I understand that the school nurse will assess my child's ability to safely do so. If my child cannot safely carry and self-administer these medications that the school may require that it be maintained in the health office.

☐ I understand school personnel have permission to communicate with the licensed prescriber regarding the use, side effects, response and contraindications of this medication and the medication may not always be administered by a nurse.

☐ I shall hold harmless and indemnify Shakopee Public Schools, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.

PRESCRIBED or OVER-THE-COUNTER MEDICATION

Medication Name		**Medication is given for treatment of**	
Dose	**Route**	**Frequency**	**Time**
☐ **This medication is only given when the student forgets to take their morning dose at home**			
☐ **This is an emergency medication and the student is authorized to self-carry and self-administer**			

Parent/Guardian Printed Name _____ Date_____

Parent/Guardian Signature _____

Licensed Provider Printed Name _____ Date_____

Licensed Provider Signature _____ Phone _____

For additional medication continue on back side

Student Name **Student ID** **DOB** **Grade** **School**

Medication Name			**Medication is given for treatment of**
Dose	**Route**	**Frequency**	**Time**
☐ **This medication is only given when the student forgets to take their morning dose at home**			
☐ **This is an emergency medication and the student is authorized to self-carry and self-administer**			

Medication Name			**Medication is given for treatment of**
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Medication Name			**Medication is given for treatment of**
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Medication Name			**Medication is given for treatment of**
Dose	**Route**	**Frequency**	**Time**
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Parent/Guardian Printed Name ____ Date____________________

Parent/Guardian Signature ____

Licensed Provider Printed Name ____ Date___________________

Licensed Provider Signature ____ Phone _________________