Forest Lake Area Schools

Authorization for Administration of Medication at School

Name of Student: _____ **Birthdate:** _____

School: _____ **School Year**: _____ **Grade:** _____

Medical Condition / ICD 10 CM	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route	Start Date	Stop Date

(All authorizations expire one year from date unless otherwise specified)

☐ Student may **self-carry / administer** his/her **inhaler/Epipen®**, with an MD order, Parent/Guardian authorization and if appropriate as determined by the School Nurse.

_____ _____

Print or Type Name of Physician / Licensed Prescriber **Signature of Physician / Licensed Prescriber**

_____ _____ _____ _____

Clinic Address Fax Number Phone Number Date

Parent / Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request that the medication(s) be given on field trips, as prescribed and per district policy.
2. I release school personnel from liability in the event adverse reactions result from taking medication(s).
3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
4. I give permission for the Licensed School Nurse (LSN) or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the medication(s) to be given by designated personnel as delegated by the LSN.
6. **I give permission for the LSN or designee to consult (in oral or written format) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to physician/licensed prescriber and parent/guardian via monitoring form.**
   This authorization may be revoked by you at any time in writing and automatically expires one year from signature

☐ My son/daughter may **self-carry / administer** his/her **inhaler/Epipen®**, with an MD order and if appropriate as determined by the School Nurse.

_____ _____

Parent/Guardian Signature Relationship to Student

_____ _____ _____

Home Phone Day Phone Date

NOTE: Medication is to be supplied in the original/prescription bottle and transported to and from the school by a parent/guardian.

Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect educational outcomes or this student's safety.

District Fax Numbers

ALC (651) 982-3172; Century (651) 982-3017; Columbus (651) 982-8957; Forest Lake (651) 982-3299; Forest View (651) 982-8260; Lino Lakes (651) 982-8891; Linwood (651) 982-1955; Montessori (651) 982-8386; Scandia (651) 982-3349; Senior High (651) 982-8594;Southwest (651) 982-8798; Wyoming (651) 982-8067; St. Peter's Elementary (651) 982-2230

(2/14)