



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

- 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.
- I release school personnel from liability in the event adverse reactions result from taking medication(s).
- I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
- 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).
- I give permission for the medication(s) to be given by designated personnel as delegated by the LSN.
- 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

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.

NOTE: Medication is to be supplied in the original/prescription bottle and transported to and from the school by a parent/guardian. Due to privacy issues, health information is not shared with programs that take place outside of the educational day.

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.

Parent/Guardian Signature _____ Relationship to Student _____

Home Phone

Day Phone

Date

District Fax Numbers: ALC (651) 982-3172; Columbus (651) 982-8957; Forest Lake (651) 982-3299; Forest View (651) 982-8260; Lino Lakes (651) 982-8891; Linwood (651) 982-1955; Middle School (651) 982-3017; Scandia (651) 982-3349; Senior High (651) 982-8594; St. Peter's Elementary (651) 982-2230 ; Wyoming (651) 982-8067