

ISD #518 Worthington Consent for Medication Administration
ALL PRESCRIPTION MEDICATION REQUIRES A
PHYSICIAN'S SIGNATURE

___ Prairie Elementary #507-727-1250 Fax #507-727-1255 ___ Middle School #507-376-4174

Fax# 507-372-1424 ___ High School #507-376-6121 Fax #507-372-4304 ___ ALC #507-372-1322

Student: _____ Date of Birth: _____ Grade: _____

Parent/Guardian: _____ Phone: _____ (W) _____

1. Reason for medication/treatment: _____

2. Name of Medication _____ Dosage: _____

() tablet/capsule () liquid () inhaler () nebulizer () other _____

3. Time Medication is to be given AT SCHOOL: _____ () with lunch () PRN

4. Start Date: _____ End Date: _____ () end of school year

5. Restrictions and/or side effects: _____ () non anticipated

6. For students with more than once daily dosing: If the morning dose usually taken at home is missed, this dose may be administered at school by school personnel. PARENT/GUARDIAN is required to notify school of missed dose at home.

Physician's Signature (for ALL prescription medications) Date

Physician name-printed

Insulin, Epi-pens, & inhalers: I have assessed this student and found him/her to be both capable and responsible for **SELF-ADMINISTERING/SELF CARRYING** this medication (school district is not responsible for missed doses of medication):

() not applicable () no () yes, with supervision () yes, unsupervised – may carry during school hours

**a photocopy of the prescription is acceptable in place of physician's signature unless the student is going to self administer/self carry the medication.

I authorize school personnel to set-up and administer the above medication to my child (unless self administration/self carry has been indicated). I understand that the **medication must be provided in a pharmacy or unopened manufacturer's labeled bottle**. Medication in plastic bags or envelopes **WILL NOT** be accepted.

***This notice gives permission for the school health office and this doctor's office to share information regarding this student's health condition to better care for the child during school hours. I give my permission for my child's medical office to fax this form to my child's school.

I give permission to send remaining medication home with my child at the end of the school year or when treatment is complete. (Controlled substances must be picked up by parent/guardian)

Parent/Guardian Signature

Date

9/16