Central Minnesota Christian School – Medication Administration Authorization

Do not use this form for students who require medication for asthma, severe allergies, seizures, or diabetes. Please have your medical provider complete action plans for these health conditions.

Student Name:______________________ Date of Birth:_________ Grade:______

PHYSICIAN AND PARENT SIGNATURE REQUIRED BELOW

Parents/guardians asking school staff to give medication to their child must provide written permission each school year that has been signed by the child's licensed health care provider **AND** the parent/guardian. The medication must be provided in the original, labeled container.

PHYSICIAN/LICENSED PRESCRIBER'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL – to be completed by physician/licensed prescriber.				
MEDICATION	DOSE IN MG	FREQUENCY	ROUTE	MEDICAL COND.
Physician/licensed prescriber signature (required):			Date:	
Print Name of Prescriber:		Clinic Name/Phone		

All authorizations expire at the end of the school year.

Parent/Guardian Authorization

1. I request that the above mediation(s) be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the medications be given on field trips as prescribed. ___YES __NO
3. I will notify the school if medication is stopped, or has a change in dosage or frequency.
4. I give permission for the medications(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
5. Legally, I may refuse to sign the authorization to administer medication form. If I refuse to sign, school will not be able to administer the medication.

Parent/Guardian Printed Name:______________________________

Parent/Guardian Signature:_________________________________ Date:_________

Permission for Release of Information

1. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical conditions to the school nurse.
2. I give permission for the school nurse to communicate, as needed, with school staff necessary for administration of medication(s) in order to provide for my child's health and safety needs at school.

Parent/Guardian Signature:_________________________________ Date:____________