

**Lake Superior School District Authorization for Administration of Medication at School/2017-2018
(Expires at end of school year-to be renewed annually)**

Name of Student: _____ Birth date: _____

Grade: _____ School (circle one): Minnehaha Two Harbors High School William Kelley Elementary William Kelley High School

Diagnosis- Medical Condition	Medication Name	Medication Strength provided in MG or MG/ML	Dosage/ Number of Tablets	Time	Frequency	Route	Duration

ICD 10-CM Diagnosis code(s): _____

Allergies: _____

Signature of Physician / Licensed Prescriber

Print Name 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 by teacher, as prescribed. I give permission for the medication(s) to be given by designated personnel trained in medication administration, as delegated by the school nurse.

I release all school personnel and the Lake Superior School District from any and all liability in the event any adverse reactions resulting from the use or administration of this 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 school nurse or designee to communicate with the student's teachers/and other school personnel about the student's health condition(s) and the action of the medication(s).

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with the staff in the school whose jobs require access to this information to ensure your child's safety and school success.

I give permission for the school nurse 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.

At the end of the school year, medication supply to be sent home-please initial below:

_____ Send with student

_____ Parent to pick up

Other _____

_____ Keep this medication at school

_____ Send this medication home each evening

My son/daughter may self-administer and carry his/her inhaler/Epi-Pen®/insulin, if appropriate as assessed by the School Nurse.
YES or NO (Please circle)

Parent/Guardian Signature

Relationship to Student

Daytime Phone

Other Phone

Date

Revised 12/16