Lake Superior School District Authorization for Administration of Medication at School 2023/24
(Expires at the end of school year-to be renewed annually)
Parent to COMPLETE ITEMS MARKED WITH *

*Name of Student: _____ *Birth date: _____ *Grade: _____

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): _____(for provider)
***Allergies:** _____

*_____ *_____ *_____
Name of Provider / Licensed Prescriber Clinic Fax Number Clinic Phone Number

Signature of Physician / Licensed Prescriber_____Date_____
(Required for prescription medication administration during the school day)

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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 the 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 of 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.

***_____ Keep this medication at school** ***_____Send this medication home each evening**

***My child may self-administer and carry his/her inhaler/Epi-Pen®/insulin, if appropriate as assessed by the School Nurse.**
YES NO NA (Please circle)
***My 10th-12th grader may keep OTC pain relief in their locker and self administer this according to the labeled instructions.**
YES NO (please circle)

*_____/_____
Parent/Guardian Signature Relationship to Student

*_____ _____ *_____
Daytime Phone *Other Phone Date

***At the end of the school year** **_____Send with student** **_____Parent to pick up**

***School (circle one): Minnehaha Two Harbors High School William Kelley Elementary William Kelley High School** Revised 8/2022