LAKE SUPERIOR School District

AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL
2026-2027

STUDENT INFORMATION		
Student Name:	DOB:	GR:
Medical Condition(s):	Known Allergies:	

MEDICATION INFORMATION			
Medication:	Dose:	Route:	Frequency:
Medication:	Dose:	Route:	Frequency:
Medication:	Dose:	Route:	Frequency:

NOTE: *All medication must be brought to school by the parent/guardian in the original container. Prescription medication must be labeled for the student by a pharmacist in accordance with law, and must be administered in a manner consistent with the instructions on the label. Mixed dosages in a single container will not be accepted for use at school (for example 5mg and 10mg tablets in the same bottle).*

PRESCRIBING HEALTH PROFESSIONAL Complete this section for *PRESCRIPTION MEDICATION ONLY*	
Signature:	Date:
Printed Name:	Clinic:
Phone:	Fax:
Diagnosis/Reason for taking medication:	

PARENT/GUARDIAN AUTHORIZATION FOR STAFF ADMINISTRATION

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 immediately notify the school of any change in the medication(s), (ex: dosage change, discontinued, etc.)

I give permission for the school nurse to consult with my student's prescribing health professional concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.

I give permission for school staff to administer the medication on a field trip, as necessary. ☐

I give permission for my student to self administer and carry their inhaler/epi-pen/insulin. ☐

Parent Signature: _____ **Date:** _____