Administration of Medication/Medical Treatment

Child's Name_____ DOB_____

Directions: Prescribed Medication/Medical Treatment Request *a) Read Section I; b) Complete Section II; c) Have your child's health provider complete Section III and IV; and d) Supply either any necessary procedure equipment/supplies or the medication to the school office in a* ***pharmacy labeled container****. Pharmacies will divide medications in two labeled bottles, one for home and one for school, upon request. This form can be mailed or hand delivered to the main office at the school, faxed to (218) 525-0024, or emailed to jjohnston@northshorecommunityschool.org.*

Directions: Over-the-Counter (OTC) Medication Request *a) Read Section I; b) Complete Section V; and c) Supply the OTC medication to the school office in its* ***original container****. This form can be mailed or hand delivered to the main office at the school, faxed to (218) 525-0024, or emailed to jjohnston@northshorecommunityschool.org.*

Section I: Parental Request for Administration of Medication

- I request that the medication and/or treatment specified on this form be given during school hours as ordered by the physician/licensed prescriber (for prescribed medication/treatment) OR as described on the OTC medication label (unless I request a dose *lower* than OTC label).
- I release school personnel from liability in the event adverse reactions result from the medication and/or treatment.
- I give permission for the medication/treatment to be given by designated school personnel.
- I understand that school personnel cannot administer prescribed medication or treatment without authorization from my child's physician/licensed prescriber and my permission.

Please sign below to indicate your permission to administer medication.

Parent/Guardian Printed Name_____ Date_____

Parent/Guardian Signature_____

Section II: Permission for Release of Information

- I give permission for the school personnel to communicate with my child's teachers and other employees that need to know about his/her health condition and the action of the medication and/or treatment.
- I understand that school personnel will share medical and/or prescription information with emergency responders, if they are called to provide care for my child.
- I give permission for the school nurse to consult (both verbally and in writing) with my child's physician/licensed prescriber regarding any questions that arise related to the medical condition and/or medication/treatment being used to treat the condition.

Please sign below to indicate your permission to release information.

Parent/Guardian Printed Name_____ Date_____

Parent/Guardian Signature_____

This form has been provided by the Minnesota Department of Health - *Minnesota Guidelines for Medication Administration in Schools* and is endorsed by the Minnesota Academy of Family Practitioners and the American Academy of Pediatrics, Minnesota Chapter.

S ection III: Physician's Order for Administration of Medication/Treatment by School Personnel

PRESCRIPTION MEDICATION

I have prescribed the following medication for this student and request that dosage(s) be given during school hours (8:00 am to 2:50 pm):

A. Medication_____ Dose _____ Route _____
Start Date _____ Stop Date _____
Time(s)_____ OR As Needed _____

B. Initial here _____ if this is a morning medication that should be given at school, ONLY if student forgets to take his/her regular dose at home before arriving at school. NSCS will call the parent to verify a missed morning dose prior to administering.

C. The medication is for treatment of_____. Possible side effects that may be seen at school include _____
_____

D. Initial ALL of the items below that apply. The student:
_____ should carry and *(check one)* □ self-administer □ NOT self-administer his/her inhaler.
_____ should carry and *(check one)* □ self-administer □ NOT self-administer his/her epi-pen.
_____ should carry and *(check one)* □ self-administer □ NOT self-administer his/her _____.

PRESCRIBED TREATMENT PROCEDURE

I have prescribed the following treatment procedure for this student during school hours:

_____
_____
_____ for treatment of_____ .

Section IV: Physician's Information

Physician's Printed Name _____ Date _____
Physician's Signature _____
Clinic/Hospital Name _____ Phone _____

Section V: Administration of Over-the-Counter Medication (OTC)

Medication 1 _____ Dose _____ Route _____
Start Date _____ Stop Date _____
Time(s)_____ OR As Needed _____

Medication 2 _____ Dose _____ Route _____
Start Date _____ Stop Date _____
Time(s)_____ OR As Needed _____

Medication will be administered according to the label unless otherwise indicated above. NSCS will not exceed the manufacturer's recommended doses.

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