WASECA PUBLIC SCHOOLS

MEDICATION REQUEST AND AUTHORIZATION FOR PRESCRIPTION MEDICATION

FOR PHYSICIAN TO COMPLETE:

STUDENT'S NAME: _____

MEDICATION/DOSAGE: _____

TIME MED IS TO BE GIVEN: _____

METHOD OF ADMINISTRATION_____

POSSIBLE SIDE EFFECTS/ REACTIONS: _____

DIAGNOSIS & REASON FOR THIS
MEDICATION:_____

PHYSICIAN'S SIGNATURE: _____DATE:_____
ADDRESS: _____
PHONE NUMBER: _____FAX NUMBER: _____

PARENT/GUARDIAN AUTHORIZATION:

1. I REQUEST THE ABOVE MEDICATION BE GIVEN DURING SCHOOL HOURS AS ORDERED BY THIS STUDENT'S PHYSICIAN.
2. I RELEASE SCHOOL PERSONNEL FROM ANY LIABILITY IN RELATION TO THIS REQUEST WHEN THE MEDICATION IS GIVEN AS ORDERED.
3. I WILL NOTIFY THE SCHOOL OF ANY CHANGE IN THE MEDICATION.
4. I GIVE PERMISSION FOR THE SCHOOL NURSE TO COMMUNICATE WITH SCHOOL STAFF ABOUT THE ACTION AND SIDE EFFECTS OF THIS MEDICATION ON A NEED TO KNOW BASIS.
5. I GIVE PERMISSION FOR THE SCHOOL NURSE TO CONSULT WITH THE ABOVE STUDENT'S PHYSICIAN OR PHARMACIST REGARDING ANY QUESTIONS THAT ARISE WITH REGARD TO THE LISTED MEDICATION OR MEDICAL CONDITION BEING TREATED BY THIS MEDICATION.
6. I UNDERSTAND I MUST PROVIDE THIS MEDICATION IN THE ORIGINAL, PROPERLY LABELED PHARMACY CONTAINER. IT IS MY RESPONSIBILITY TO MAKE SURE THE MEDICATION IS AT SCHOOL.
7. I UNDERSTAND THAT MEDICATION SHOULD BE TRANSPORTED TO AND FROM SCHOOL ONLY BY AN ADULT. THE SCHOOL WILL NOT SEND THIS MEDICATION HOME WITH A CHILD.
8. FIELD TRIPS: I GIVE PERMISSION FOR THE ASSIGNED TEACHER/RESPONSIBLE ADULT TO ADMINISTER THE MEDICATION ON A FIELD TRIP, AS NECESSARY, FOLLOWING SCHOOL PROCEDURES.

SIGNATURE OF PARENT/GUARDIAN: _____DATE:_____

RELATIONSHIP TO STUDENT: _____ DAYTIME PHONE: _____