Health Services ISD #2134 United South Central School

CONSENT FOR ADMINISTRATION OF OVER THE COUNTER AND PRESCRIPTION MEDICATION DURING SCHOOL DAY

Order expiration date _____ **ICD 10 Code**_____

Pupil Name _____ DOB _____ School _____

Pupil Address _____ Grade _____ School Year _____

Parents of pupils requesting that **any** medication be administered during school hours by school staff are requested to provide for the school:

1.) the physician's order
2.) a parental release, and
3.) medication supplied in the original container
4.) Ask for prescription medication to be divided in two bottles completely labeled, one for home and one for school.

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I have prescribed the following medication for this student and request that dosages are given during school hours:

Medication _____ Dose _____ Route _____

Time to Administer _____ PRN Repeat Frequency _____

(morning medication dose ___mg. to be given at school only if student forgets to take at home)

Diagnosis/medical reason for medications _____ Possible side effects_____

Special instructions_____ Last date to be given _____

Other medications taken at this time _____ Medication allergies _____

Inhalers & EpiPens: Child has received instruction and permission for self-administration ___Yes ___ No

Physician and I agree that this student needs medication on field trips ___ Yes ___ No

Physician's Name (Print) _____ Fax Number _____

Physician's Signature _____ Date _____ Phone _____

Parent/Guardian Authorization

1.) I request that the above medication be given to my child during school hours (no after school activities) as ordered by this student physician.
2.) I give permission for the school nurse/designee to consult with this child's physician concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.
3.) I give permission for the school nurse to communicate with appropriate school personnel about the action and side effects of this medication.
4.) I will provide this prescription medication in the original properly labeled pharmacy bottle.
5.) I will provide the over the counter medication in the original manufactured sealed bottle.
6.) Field Trips- I give permission for a teacher/school personnel to administer the medication on a field trip.
7.) I release school personnel from any liability in relation to the administration of the medication at school, (the school nurse will not necessarily do administration of this medication.)
8.) ***To promote safety, medication information may be shared with the school personnel working with your child and with 911 personnel, if they are called***

Parent/Guardian Signature _____ Date _____

Date order noted _____ By _____

Nurse Signature (all orders must be noted by an RN)

Revised 6/1/2015 S. Martin MS RN PHN LSN

United South Central School District #2134

Self Administration of Over-the-Counter Medication Authorizations
Parent/Legal Guardian's Request and Authorization for Self Carry/Self Administration

I request and authorize my child_____ (child's name) to carry and/or self administer (circle one or both)
their over the counter medication_____.

This authorization is given based on the following:

- My child is capable of and has been instructed on the proper method of self-administration of this medication according to the manufacturers label.
- I understand that the medication must be brought to school in an original, unopened bottle/package and must remain in original bottle/packaging while at school.
- I understand that my child shall be permitted to carry their medication as long as they do not endanger him/herself or other persons and will not misuse the medication.
- I understand that if my child misuses this medication by not taking the manufacturer's recommended dosage, or endangers others with the medication, school employees or agents may confiscate the medication.
- I understand that my child may not possess medication containing ephedrine or pseudoephedrine as its sole ingredient or as one of its active ingredients.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.

Parent/Legal Guardian Name (Print)_____

Parent/Legal Guardian Signature_____Date:_____

Adapted for USC Schools from MDH Minnesota Guidelines for Medication Administration in Schools (June of 2015)
Revised 11/12/2018 Taryn Eilertson RN