

ST. CLOUD AREA SCHOOL DISTRICT 742

Public and Non-Public Schools

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AND/OR TREATMENT

THE PURPOSE OF THIS CONSENT FORM IS TO AUTHORIZE THE SAFE AND NECESSARY ADMINISTRATION OF MEDICATION AND TREATMENTS IN SCHOOL AND TO AUTHORIZE PROFESSIONAL CONSULTATION WITH THE PRESCRIBING LICENSED PRACTITIONER ABOUT THIS ORDER. ORDERS MUST BE RENEWED ANNUALLY OR WHENEVER THERE IS A CHANGE IN MEDICATION, DOSAGE OR FREQUENCY.

- Parents/guardians will complete "Authorization for the Administration of Medication and/or Treatment" form (NS13.3) when a medication is brought to school, or within one school day.
- Medication must be brought to school by a parent or responsible adult.
- Prescribed medication can be administered at school only if there is no alternative and when accompanied by a physician's order and in a pharmacy labeled container.
- Non-prescription (over-the-counter) medication may only be administered at school when accompanied by a physician's order and in a pharmacy labeled container.
- Administration of drugs and medicine is to be done only by the licensed school nurse or delegated personnel.
- Dietary supplements and non-FDA approved alternative medications will not be administered at schools.
- It is the parent's/guardian's responsibility to provide school personnel with medication that is pharmacy labeled. The containers must have the same name of the student, the name of the physician, the name and dosage of the drug, directions for administering the medication at school and the date filled. Parents/guardians will be contacted if labeling is inadequate or the prescription is outdated.

I hereby request the licensed school nurse, or other authorized personnel, to give medication as prescribed by a physician and/or requested by a parent, to the child described below. I release the school personnel from liability in the event any reaction results from the named medication. This authorizes the licensed school nurse to contact the physician for any further information needed regarding the medication or the condition being treated.

_____		Signature of Parent/Caregiver	Date
Birthdate_____			
Name of Student_____	School_____	Grade/Teacher_____	
Name of Parent/Caregiver_____		Home Phone_____	
		Cell Phone_____	
Name of Doctor_____		Telephone_____	
Clinic Name_____		Fax Number_____	
Diagnosis_____			
Name of Medication_____		Time of Day to be Given_____	
Amount_____			
*My child takes the following prescriptions at home:			
Medication	Dosage	Times	
_____	_____	_____	
_____	_____	_____	

Licensed School Nurse Approval Signature

Date