Independent School District #2397
Le Sueur-Henderson Public Schools

AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS

Student Name: ___________________________ Birth date: ____________ Grade: ___

NOTE: Whenever possible, medication should be given at home and every effort should be made to avoid school hours.

TO BE COMPLETED BY PHYSICIAN:

Name of Medication: ____

Diagnosis/Medical Reason for Medication: _____________________________________

Prescribed Dosage and Means of Administration: _______________________________

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Time to be Taken During School Hours: _______________________________________

Possible Side Effects and Adverse Reactions: ___________________________________

Other Recommendations: ____

Physician Signature ____ Date: ___________

Print Name: _______________________________________ Phone: ________________

TO BE COMPLETED BY PARENT/GUARDIAN:

FOR PRESCRIPTION MEDICATION:

1. I request that the above medication be given to my child during school hours (no after school activities) as ordered by this student's physician.
2. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of it.
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 medication in the original, pharmacy-labeled bottle.
5. Field trips – I give permission for the teacher/school personnel to administer the medication.
6. I release school personnel from any liability in relation to the administration of this medication at school.

Parent/Guardian: ____ Date: ___________

School Nurse: ____

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