

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATIONS

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

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child, _____, grade _____, be allowed to self-administer the medication as listed below, including inhalers (MN Statute 121A.221).

I understand that MN Statute 121A.222 allows for **secondary** students to possess and use non-prescription pain relievers (i.e. Tylenol, Ibuprofen) with parent permission. This does not apply to the possession or use of any product containing ephedrine or pseudoephedrine (i.e. Sudafed) or any prescription medication.

A district may revoke the privilege if there is reason to believe the student is abusing that privilege.

Name of Student _____

Medical Condition _____

Name of Medication _____

Dosage and Means of Administration (i.e. Oral, Inhaler) _____

Time to be Taken During School Hours _____

Comments _____

Signature (Parent or Guardian) _____

Phone Number _____ Date _____

Signature (School Nurse) _____

Date Received _____

(Update required each school year)