ISD 728 INDEPENDENT SCHOOL DISTRICT 728

ELK RIVER | OTSEGO | ROGERS | ZIMMERMAN

Health Services Department
11500 193rd Ave. NW
Elk River, MN 55330
p: 763.241.3400
f: 763.241.3410
health.services@isd728.org
www.isd728.org

AUTHORIZATION for ADMINISTRATION of MEDICATION at SCHOOL

Minnesota Statutes 121A.22

Student:_____ Birth Date: _____

School: _____ School Year: _____ Grade: _____

PHYSICIAN'S AUTHORIZATION: Physician complete ALL information

Medical Condition/ICD-10	Medication	Strength	Dose	Time	Route	Possible Side Effects
1. ICD 10:						
2. ICD 10:						
3. ICD 10:						

Other considerations/directions: _____

Start date: _____ Stop date: _____ (*All authorizations expire at the end of the school year or following summer school session.*)

_____ _____ _____

(Print) Name of Physician/Licensed Prescriber **Signature of PhysicianL/Licensed Prescriber** Date

_____ _____ _____

Clinic Address Phone Fax

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

NOTE: Medication must be supplied in the original/prescription bottle.

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s) i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the licensed school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
6. I give permission for Health Services personnel to communicate as needed with school staff about my child's medical condition(s) and the action of the medication.
7. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s).

_____ _____

Parent/Guardian Signature Relationship to Student

_____ _____

Daytime Telephone Number Date