South St. Paul Public Schools

# SOUTH SAINT PAUL SPECIAL SCHOOL DISTRICT # 6
# CONSENT FOR MEDICATION ADMINISTRATION

Parents/guardians of students requesting that medication (either prescription or over-the-counter) be administered during school hours by school personnel are required to provide for the school:

1. A written parental release for the administration of medication, **and**
2. A signed statement from the licensed prescriber, **and**
3. Medication in the original container or pharmacy-labeled container

**NOTE:**

- New medication orders are required annually and when changes are made from original orders.
- Parents are asked to deliver any prescribed medications to the Health Office. If this is absolutely impossible, parents are to call the Health Office with the amount of medication sent with the student.
- Orders may be FAXED if they contain all the information included in the form below.
- Lincoln Center (651-457-9423) High School (651-457-9455) Kaposia Education Center (651-457-9453)

## Student Information

Student's Name _____ Date of Birth _____

School _____ Grade_____ Teacher _____

## Licensed Prescriber's Order For Administration Of Medication By School Personnel

I have prescribed the following medication for this student and request the dosage(s) given during school hours be administered by school personnel under the delegation/supervision of the Licensed School Nurse.

Medication/Dosage/Time of Administration:_____

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**ICD 10 CM Code**: _____Purpose/Condition for which prescribed:_____

Termination Date: _____ To be taken on a: ❑ Full Stomach ❑ Empty Stomach

Significant Side Effects:_____

❑ This student will keep inhaled medication in the Health Office.

❑ This student uses inhaled medication. The student has been instructed on proper use, side effects and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use as needed according to Licensed Prescriber's orders.

**Licensed Prescriber's Signature** _____Date _____

**Clinic** _____Phone_____Fax_____

## Parent/Guardian Release For Administration Of Medication

I request this medication be given as ordered by the above licensed prescriber. I give my permission for the Licensed School Nurse to contact the prescriber regarding questions/concerns related to my child's medication.

**Parent/Guardian Signature** _____Date _____