ST. PAUL SCHOOL OF NORTHERN LIGHTS

# Medication Authorization Form

**School Year _____**

Student: _____ DOB: _____ Grade _____

## PHYSICIAN/LICENSED PRESCRIBER –PLEASE COMPLETE

DIAGNOSIS/SIGNIFICANT FINDINGS:

HISTORY:

ALLERGIES:

| **MEDICATIONS REQUIRED DURING SCHOOL HOURS**<br>***All authorizations expire at the end of the school year.*** | | | | | |
|---|---|---|---|---|---|
| Medical Condition | Medication | Strength | Time | Route | Possible Side Effects |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

*****Medication is to be supplied in the original/prescription container.*****

| **TREATMENTS/PROCEDURES REQUIRED DURING SCHOOL HOURS**<br>(i.e. blood glucose monitoring) | | | |
|---|---|---|---|
| Medical Condition | Treatment/Procedure | Time(s) | Special Instructions |
| 1. | | | |
| 2. | | | |

Inhaler:

- ❏ Student may carry/self administer his/her inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ❏ It is my professional opinion that this student **should not carry** his/her inhaled medication.

Epi Pen:

- ❏ Student may carry/self administer his/her Epi-Pen/auto-injector according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ❏ It is my professional opinion that this student **should not carry** his/her Epi-pen/auto-injector.

_____ _____ _____

Print Name of Physician/Licensed Prescriber | Physician's/Licensed Prescriber's Signature | Date

_____ _____

Clinic Address | Clinic Phone #

**This form can be e-mailed to info@schoolofnorthernlights.org or sent to 426 Osceola Ave. S. St. Paul, MN 55102.**
**(Parent/Guardian Authorization on Reverse Side)**

# Parent/Guardian Medication Authorization

**Student: _____ DOB: _____ Grade: ____ Allergies: _____**

1. I request that the medication(s) and/or treatment(s)/procedure(s) ordered be given / performed during school hours as ordered by this student's physician/licensed prescriber.

2. I will provide the school with physician/licensed prescriber authorization **for any change** in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)

3. I give permission for school staff to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.

4. I give permission for school staff to communicate as needed about my student's health condition(s) and the action of the medication(s) and/or treatment(s)/procedure(s).

5. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designated personnel in the school.

6. I understand that school personnel cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from my student's physician/licensed prescriber.

7. Only daily medications and those for life threatening/emergency conditions will be sent on field trips. The administration of medications and delegation may be different when on field trips.

8. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).

_____ _____ _____

Date Parent/Guardian Signature Relationship to Student

Parent Phone Numbers: _____ _____

## Self-Administration of Medication Student Agreement

**I, _____ agree to:**

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Maintain a written record of my medication administration at school (form, assignment notebook)
- Not allow anyone else to use my medication.
- Keep a current supply of my medication located: _____.
- I will make sure I have my medication available for field trips or other off-site school events.
- Notify the office of any of the following circumstances: -My symptoms continue or get worse after taking my medication -I suspect that I have side effects from my medication -I need my medication more frequently than ordered (i.e., inhaler more than every 4 hours).

_____ _____

**Signature of Student** **Date**

**The student has demonstrated knowledge about and proper use of his/her medication:**

_____

**Signature of Health Office Staff** **Date**