MEDICATION AUTORIZATION FORM

Name _____ **D.O.B.** _____

PARENT/GUARDIAN PORTION - PLEASE READ AND SIGN/DATE BELOW

Parent/Guardian: This form needs to be filled out by BOTH a parent/guardian **and** a physician/licensed provider. It then needs to be returned to the school health office before any medications, procedures, or treatments can be given to your child during the school year. Communication between the medical community and school(s) provides positive health outcomes for students, families, and communities. Completion of this form and returning it to the health room at your child's school enhances coordination of services and also promotes an optimal learning environment.

PLEASE NOTE: WE WILL NOT DISPENSE ANY MEDICATIONS OR PERFORM TREATMENTS/PROCEDURES WITHOUT THIS COMPLETED FORM BEING ON FILE.

_____Please FAX this form to my child's school health office ***Fax number 952-469-4484***

_____I will have this form filled out and will return it to my child's health room at **All Saints Catholic School** for the _____ school year

1. I understand that school health personnel cannot administer medication(s), give treatment(s), and/or procedures indicated on this form without authorization from my child's physician or licensed provider.
2. I request that the medication(s) and/or treatment(s) /procedure(s) specified on this form be given during school hours as directed by this child's physician/licensed prescriber following the district medication policy and procedures.
3. I understand that the school intends to use the requested information to provide for my child's health and safety needs during school hours. I also may refuse to supply the requested personnel information, but the consequences for not providing the health information or medications may result in my child not being able to take medication(s)/treatment(s) from the health office.
4. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedures(s).
5. I will provide the school with the physician/licensed prescriber authorization for any change in the medication(s) and/or treatment(s) or/procedure(s). For example: dosage change, time change, or discontinued medication(s).
6. I understand that the procedure for administering medication on a field trip may be different from the medication administration during the school day.
7. I give my permission for the health aide/district nurse to communicate with the child's teacher(s) about the health condition(s) and the action of the medication(s) and or treatment(s)/procedure(s).
8. I give my permission for the health aide/district nurse to consult (verbally and in writing) with the above named child's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s), treatment(s), or procedure(s) being used to treat the condition.
9. I give my permission for the medication(s) and/or treatment(s) to be given by designated personnel as delegated by the District Nurse and I understand that a nurse may not necessarily give medication.
10. This consent may be revoked at any time by giving written OR verbal notice to the school health office.

_____ _____ _____

Date **Parent/Guardian Signature** **Relationship to Child**

A Physician/Licensed Provider MUST complete the back side of this form

HOSPITAL - EMERGENCY ROOM – CLINIC – and SCHOOL
COMMUNICATION RECORD

(PHYSICIAN/LICENSED PRESCRIBER – PLEASE COMPLETE THE FOLLOWING)

Diagnosis/Significant Findings: _____
History: _____
Allergies: _____ _____ _____ _____ _____

MEDICATIONS REQUIRED DURING SCHOOL HOURS

Medical Condition	Medication Name	Strength	Dose	Time Given	Route	Possible Side Effects
1.						
2.						
3.						
4.						
(ALL Medication(s) is to be supplied in the original/prescription container)						

- **Student may carry/self administer his/her EPI-PEN injector.** He/she has been instructed on proper use, side effects, and safeguards regarding the medication. He/she is authorized to keep this medication with them during the school day and to use as needed.
- **Student ay carry/self administer his/her INHALER**. He/she has been instructed on proper use, side effects, and safeguards regarding this medication. He/she is authorized to keep this medication with them during the school day as needed according to the licensed prescriber's instructions.

TREATMENTS OR PROCEDURES REQUIRED DURING SCHOOL HOURS

(i.e., peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes)

Medical Condition	Treatment/Procedure	Time(s) Frequency	Special Instructions
1.			
2.			

Additional Information:

_____Return to school with NO limitations
_____REST AT HOME through___/___/___ or until next visit
_____MODIFY the following activities during the school day through ___/___/___ or until the next scheduled visit:

_____Physical Education _____Ambulation
_____Sports _____Diet

PLEASE SPECIFY: _____
_____

_____ _____ _____
Date PRINT name of Physician/Licensed Prescriber Physician/Licensed Prescriber Signature

_____ _____ _____
Clinic Address Phone # Fax #