PRESCRIPTION MEDICATION

PHYSICIAL ORDER FOR MEDICATION AND PARENT/GUARDIAN AUTHORIZATION FORM

(TO BE RENEWED ANNUALLY)

Student: _____ Date of Birth: _____
Parent/Guardians: _____
School: _____ Teacher/Grade: _____

PHYSICIAN'S ORDER

I hereby request and authorize you administer to the above named student:

MEDICATION	DOSAGE	TIME	DURATION
1.			
2.			
3.			

Diagnosis/Medical reason for medication:_____
Other medications that child is taking:_____
Allergies:_____

I recommend that this student is knowledgeable about the use of this medicine/inhaler and can self administer:
_____YES _____NO
Physician's Signature_____ Date_____
Print Physician's name_____ Phone #_____
Clinic_____ Fax#_____

PARENT/GAURDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this student's physician.
2. I will immediately notify the school of any changes in the medication or physician's order, dosage, change, frequency, or duration of administration.
3. I give my permission for the school nurse to communicate with other school personnel about the action, use, effect and side effects of the medication.
4. I give my permission for the school nurse to consult with the student's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
5. I release all school personnel and the Bagley or Clearbrook/Gonvick Schools from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
6. The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure you child's safety and school success.

_____ Phone #_____ (H) _____
(parent/guardian) signature date
Phone#_____(W)

7. Study Trips:
   a) I give my permission for the teacher/responsible adult to administer the medication on a study trip, as necessary,
   following school procedure.
   b) I release all school personnel, the Bagley or Clearbrook/Gonvick Schools, and any responsible adult administering the medication form any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

_____Phone#_____ (H) _____
(parent/guardian) signature Phone#_____ (W) date