

## Zumbro Education District Medication Authorization Form

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

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

<u>Medication:</u> (please use separate form for each medication)	<u>Dosage:</u>	<u>Time:</u>	<u>Duration:</u>	<u>Controlled medication:</u> YES / NO
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Diagnosis/medical reason for medication:

ICD-10 Code:

Other medications the student is taking:

Allergies:

Other recommendations/unusual side effects:

**PHYSICIAN'S SIGNATURE REQUIRED** for all prescription medications and over-the-counter medications that exceed package recommendations or contain aspirin.

*Parent signature only for over-the-counter medications kept at school.*

Physician/Providers Signature

Date:

Print Providers name

I believe that the above named student is capable of self carrying/self administering the medication listed above ☐ Yes ☐ No

Clinic:

Phone:

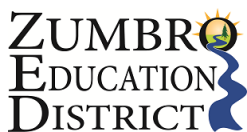
Fax:

### PARENT/GUARDIAN AUTHORIZATION FOR STAFF ADMINISTRATION:

1. I request that the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school of any change in the medication (e.g. dosage change; medication is discontinued before the duration stated in the Dr.'s order, different time for administration, etc).
4. I give permission for the school nurse to communicate with teachers about the action and side effects of this medication as needed.
5. I give permission for the school nurse to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication, if needed.
6. Field trips – I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
7. I understand that it is my responsibility to pick up any leftover medication at the end of the current school year. Any medication that is uncontrolled/over-the-counter and is not picked up after reasonable attempts by staff will be disposed of by a district designated staff person in a drop-off box or at a collection site. Any controlled medications that are left will be picked-up by a law enforcement agency and will be transported to a drop-off box or collection site on behalf of the district.

Parent signature:

Date:



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**Student Self Administration Authorization:** Self-administration is allowed for inhalers, epi-pens and diabetic medications. Other requests for self-administration will be handled on a case by case basis with the school nurse.

### PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

1. I give permission for my student to self-administer medication(s) during school hours. I have read the student agreement below.
2. I have read and understand the district medication policy 516.
3. I understand my student will carry this medication at school. I also understand my student is entirely responsible for the use of this medication and will not be monitored by school personnel.

Signature of Parent/Guardian:

Date:

### SELF-ADMINISTRATION OF MEDICATION – STUDENT AGREEMENT

☐ Inhaler

☐ EpiPen

☐ Other: (contact nurse first)

I agree to:

1. Follow my prescribing health professional's medication orders.
2. Use correct medication administration techniques.
3. Not allow anyone else to use my medication.
4. Keep a supply of my medication with me in school and on field trips.
5. Notify the school nurse or health office personnel if the following occurs:
  - ☐ My symptoms continue or get worse after taking the medication.
  - ☐ My symptoms reoccur within 2-3 hours after taking the medication.
  - ☐ I suspect that I am experiencing side effects from my medication.
  - ☐ If I have any symptoms of an allergic reaction.
6. I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established in this agreement.

Signature of Student:

Date:

### TO BE COMPLETED BY THE LICENSED SCHOOL NURSE OR REGISTERED NURSE

The student has demonstrated knowledge about and proper use of his/her (check one)

☐ Inhaler

☐ EpiPen

☐ Other: \_\_\_\_\_

Licensed School Nurse Signature:

Date: