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:				
Medication: *(please use separate form for each medication)*	**Dosage:**	**Time:**	**Duration:**	**Controlled medication:** YES / NO
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:**