

Authorization for Dispensing Medication

Note: Medications are given at school ONLY when a student wouldn't be able to attend without it. Whenever possible, medication should be given at home.

I request that my child _____, grade _____, school _____, receive the medication as prescribed by our physician or the over-the-counter medication as listed. The medication is to be furnished by me as required by the Student Medication Policy 516 (M.S. 121A.22). I UNDERSTAND THAT THE DISTRICT IS RENDERING A SERVICE AND DOES NOT ASSUME ANY RESPONSIBILITY FOR THIS MATTER. I further understand that the school health paraprofessional or other designated person will administer the medication.

Medication (Prescription or over the counter):

Time(s) to be taken during school: _____. Comments: _____

Parent/Guardian signature _____ Date _____

Phone (H) _____ (W) _____

Please administer the above named medication to _____ for
(student name)

(condition)

This authorization is in effect for the school year in which it is written unless otherwise noted here.

(Physician signature)

(Printed physician name)

If appropriate, my child/patient should carry this medication and self-administer (for epi-pens and inhalers). They have been instructed on how and when to take it and are responsible for maintaining adequate amounts. (initial for self administration)

MD _____ Parent _____