351 6th Street, P O Box 125, Lafayette MN 56054
Phone 507-228-8943 Fax 507-228-8288

2019-20 Medication Authorization - for administration of medication at the school

In order to give medication (prescription or over-the-counter) during school hours, parents will need to:

- Complete this medication authorization form including a written physician's order and parent signature authorizing staff to dispense medication to your child.
- If a student needs to carry medication with them (inhalers, Epi-pens) please have the physician identify this in the written order.
- Send Prescription medication in original container with pharmacy label identifying student name, drug, dosage, time medication should be given and physician's name. The student's name must be on the prescription original container.
- Prescription or medication must be enclosed in a sealed bag and have the student or parent bring the medication to the school office. The school office will have a refrigerator for medication and a locked file to hold the medication until the directed day and time it shall be dispensed to the student.
- Non-prescription medication does not require a physician order if the non-prescription medication is to be given as directed on the original container or box label. This medication must not have a broken seal and must come to the school in a new container or sealed box. The parent's signature on this form must accompany non-prescription (over-the-counter) medication.

STUDENT NAME____**GRADE**__________**DATE**________________

Physicians Order for Administration for Medication by School Personnel

I have prescribed the following for this student and requested the dosages be given during school hours.

Medication____

Dose and Time(s)__________________________________Start Date________End Date_________

Possible side effects____

Diagnosis or reason for medication ____

Special Instructions ____

If this Medication is to be given as needed, please explain when it should be given:________________________

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Physician's Signature ____________________________________Date ________________

Print Physician's Name____________________________________Date ________________

Parent Authorization for Administration of Medication

I hereby give permission for my child to receive medication at school as prescribed by the child's doctor, nurse practitioner or dentist. I authorize reciprocal release of information related to the medication between the school nurse and prescribing health professional.

____________________	____________________	____________________
Signature of Parent/Guardian	Daytime Phone	Home Phone

This form or the physician's order may be faxed to the attention of the school nurse at fax # 507-228-8288

Revision 7/9/19