The International School of Minnesota

School Year 2017-2018

Authorization for Administration of Prescription Medication

Student Name _____ Birthdate _____ Grade _____

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					

Date Medication is to: Begin _____ End _____

(Authorization expires automatically at the end of the school year or the summer school session.)

_____ _____ _____

Signature of Physician/Licensed Prescriber Print Name of Physician/Licensed Prescriber Date

_____ _____ _____

Clinic Address Phone Fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request that the medication be given on field trips as prescribed.
2. I will notify the school of any change in the medication(s), (i.e. dosage change, medication is stopped, etc.).
3. I give permission for the school nurse/health para to communicate as needed with school staff about my child's health condition(s) and the action of the medication(s).
4. I give permission for the school nurse/health para to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).

Parent/Guardian Signature Date Relationship to Student

NOTE: ALL PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE.

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