ROCK RIDGE PUBLIC SCHOOLS-MEDICATION ADMINISTRATION AUTHORIZATION

Phone: 218-749-5437 Fax: 218-741-8522 Phone: 218-722-7711 Fax: 218-744-4381

Virginia Campus: **Parkview**☐ **Roosevelt**☐ **VHS**☐ Eveleth/Gilbert: **Franklin**☐ **Nelle Shean**☐ **E/G HS**☐

*****Students who require medication for asthma, severe allergies, seizures, or diabetes, please have your medical provider also complete a medical action plan for the health condition(s).*****

Student: _____ Date of Birth:_____ Grade: _____

Parents/guardians asking school staff to give medication to their child must provide written permission each school year that has been signed by the child's licensed healthcare provider and the parent/guardian. The medication must be provided in the original, labeled container.

PHYSICIAN/LICENSED PRESCRIBER'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL-To be completed by physician/licensed prescriber.

Medication	Dose in mg	Frequency	Route	Medical Condition

Physician/licensed prescriber signature (required):	Date:
Print Name of Prescriber:	Clinic Name:
Phone:	Fax:

Parent/Guardian Authorization/Permission for Release of Information

1. I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the medications be given on field trips as prescribed.
3. I will notify the school if medication is stopped or changed.
4. I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
5. Legally I may refuse to sign the authorization to administer medication form. If I refuse to sign, we will not be able to administer the medication.
6. This consent may be revoked at any time by sending a written notice to the school nurse.
7. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s) in order to provide for my child's health and safety needs at school.
8. I give permission for the school nurse to contact my child's physician/licensed prescriber with questions about the above listed medication(s) or medical condition(s) being treated by medication(s).
9. I give permission for the school nurse to contact my child's physician/licensed prescriber to release information related to the above medication/s and medical condition(s) to the licensed school nurse.
10. **All medication must be picked up on or before the last instructional day or it will be discarded.**

_____ _____

Parent / Guardian Signature Date

Revised 5/10/21