Cloquet Public Schools
Medication Administration Authorization

If your student requires a medication for asthma, life-threating allergies, seizures, or diabetes have your medical provider complete an action plan.

Student: **DOB:** **Grade:** **School**

Physician/licensed prescriber's Order for Administration of Medication by School Personnel—To be completed by physician/licensed prescriber.

Medication	Dose in mg	Frequency/Time	Route	Medical Condition ICD-10-CM

It is acceptable for student to carry inhaler and self-administer as directed. Yes: ____ No:___

Physician/Licensed prescriber signature (required): Date:

Print Name of Prescriber ClinicName

Phone: Fax:

****Authorizations **expire** at the end of the school year or following the summer school session.

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.
2. I request that the medications be given on field trips as prescribed. _____Yes _____No
3. I will notify the school if medication is stopped
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 medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

_____ _____

Parent/Guardian Signature Date

Permission for Release of Information

1. 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.
2. 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.
3. I give permission for the physician/licensed prescriber to release information related to the above medication/s and medical condition/s the licensed school nurse.

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Parent/Guardian Signature Date