Minnesota New Country School, ISD #4007

✦✦ NURSE FILE ✦✦

PHYSICIAN / DOCTOR'S AUTHORIZATION for PRESCRIPTION medication at school

Please fax to school at:

#________________________

**** PLEASE NOTE: Whenever possible, medication should be given at home, and every effort should be made to avoid school hours.**

Name of Student:_____________________________ Date of birth:___________ Grade:____

TO BE COMPLETED BY PHYSICIAN: *(REQUIRED)*

Diagnosis/medical reason:____

Medication and prescribed dosage:____

- Means of administration:____
- Time to be taken during school hours:____

Expected duration of treatment:____

Possible side effects or adverse reactions:____

Other recommendations:____

____

Physician/Health Care Provider Signature:______________________________ Date:_______________

Physician Name: (please print)____

Location of clinic:________________________________ Clinic phone: ___________________________

TO BE COMPLETED BY PARENT /GUARDIAN: *(REQUIRED)*

1. I request that the above physician-ordered medication be given to my child during school hours.
2. I give permission for school health personnel to communicate with the student's physician regarding the listed medication, medical condition, or side effects.
3. I give permission for school health personnel to communicate with appropriate school staff about the action and side effects of this medication.
4. **I will provide this medication in the original pharmacy-labeled container.**
5. I understand that the school district is providing a service and does not assume any liability for this service.

Parent/Guardian Name (please print) ____

Daytime Phone where parent can be reached w/ questions (required) _______________________

Signature of Parent/Guardian (required) ____

Date (required)___________________

For school staff only -- NOTES: