

PiM ARTS HIGH SCHOOL HEALTH SERVICES

Authorization for Administration of Prescription/Over the Counter Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission from themselves and the health care provider every school year.

Student: _____ DOB: _____ Grade: _____

School year: _____

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
2.					
3.					
4.					

Start date: _____ Stop date: _____
 (Authorization expires at the end of the school year or following 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 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 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).				
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____ Parent/Guardian signature</td> <td style="width: 20%; border: none;">_____ Date</td> <td style="width: 30%; border: none;">_____ Relationship to Student</td> </tr> </table>			_____ Parent/Guardian signature	_____ Date	_____ Relationship to Student
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NOTE: Medication is to be supplied in original/prescription bottle.

Return to front office staff Phone: 952-224-1340 FAX: 952-224-2955 Updated 3/15/2021

Date Received: _____ Received By: _____