NOTRE DAME ACADEMY

Authorization for Administration of 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. If your child uses an inhaler or takes any medications during school hours, please fill out this form. If your child uses over the counter medication for headaches or braces, **you** may sign the form. Please bring in the completed form and medications on Back to School Night.

Student:____ BD:_________ Grade:_____

School:____ School year:_____________

Notre Dame Academy Fax #952-935-2031

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
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).

Parent/Guardian signature   Date   Relationship to Student

NOTE: MEDICATION IS TO BE SUPPLIED IN THE ORIGINAL PRESCRIPTION BOTTLE

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