Willow River School District #577 Health Office
8142 Pine Street Willow River, MN 55795 218-372-3131 x103

Authorization For Medication Administration School Year 2020-2021
(Expires at the end of school year-to be renewed annually)

Name of Student: _____ Birthdate: _____ Grade: _____

Diagnosis-Medical condition	Medication Name	Medication Strength provided in MG or MG/ML	Dosage/Number of tablets	Time	Frequency	Route	Duration

ICD 10-CM Diagnosis Code(s): _____
Allergies: _____

_____ _____
Signature of Physician/Licensed Prescriber Print Name of Physician/Licensed Prescriber

_____ _____ _____ _____
Clinic Address Fax Number Telephone Number Date

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Parent/Guardian authorization
I request that the above medication(s) be given during school hours as ordered by this student's Physician/Licensed Prescriber. I also request that the medication(s) be given on field trips by the teacher as prescribed. I give permission for the medication(s) to be given by designated personnel trained in medication administration, as delegated by the school nurse.

I release all school personnel and the Willow River School District from any and all liability in the event any adverse reactions result from the use or administration of this medication(s).

I will notify the school nurse of any change in the medication(s), (example: dosage change, medication is discontinued, etc.)

I give permission for the school nurse or designee to communicate with the student's teachers/and other school personnel about the student's health condition(s) and the action of the medication(s).

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequences for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with the staff in the school whose jobs require access to this information to ensure your child's safety and school success.

I give permission for the school nurse or designee to consult (in oral or written format) with the above named student's Physician/Licensed Prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to Physician/Licensed Prescriber and parent/guardian.

At the end of the school year, medication supply to be sent home-please initial below:

_____Send with student

_____Parent to pick up
Other: _____

_____ Keep this medication at school _____ Send this medication home each evening Other: _____

My Son/Daughter may self-administer and carry his/her Inhaler/Epi-Pen/Insulin, if appropriate as assessed by the school nurse.
Yes/No (Please Circle)

_____ _____
Parent/Guardian Signature Relationship to Student

_____ _____ _____
Daytime Phone Other Phone Date

Google Doc: 5/5/20; Revised: