Administering Prescription Medications

For Mora Public Schools

320-679-6232

Please fill out all areas if you wish to have medications administered to your child during school hours by school staff.

Student _____ Birth Date _____ / _____ / _____

School _____ Grade _____

Physician's Order for Administration by School Personnel

I have prescribed the following medication(s) for this student and request the dosages be given during the school hours.

	Medication	Dose	Time(s)	Diagnosis	Side Effects
1.					
2.					
3.					

(All authorizations expire at the end of the school year or at the end of extended school year summer programs)

Physician Signature _____ Date _____

Clinic _____ Clinic fax _____

Clinic phone _____

Parent / Guardian Authorization of Medication

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, as prescribed.
I release school personnel from liability in the event adverse reactions result from taking medication(s).
I will notify the school of any change in the medication(s), (ex. dosage change, medication is discontinued, etc.)
I give permission for the school nurse or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
I give permission for the school nurse or designee to consult (in oral or written format) with the above names 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 via monitoring form.

☐ My son/daughter may self-administer his/her inhaler/Epipen®, if appropriate as assessed by the School Nurse.

_____ _____

Parent/Guardian Signature Relationship to Student

_____ _____ _____

Home Phone Day Phone Date

NOTE: Medication is to be supplied in the original/prescription bottle. Ask the pharmacy to divide the prescription into two separate bottles. One labeled Home and one labeled School

Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect education outcomes or this student's safety.

RETURN TO: Mora Public Schools, School Nurse

Mora Elementary Health Office
200 N 9th St Mora, MN 55051

Mora High School Health Office
400 E Maple Ave Mora, MN 55051

OR: Health Office Fax:

Mora Elementary School:
320-679-6249
Mora High School:
320-679-6238

MORA MUSTANGS

Exploring. Engaging. Empowering.

Mora Independent School District #332
400 East Maple Avenue Mora, MN 55051
District Nurse Health Office School Phone (320) 679 – 6232
Elementary Fax: (320) 679 – 6249; High School Fax: (320) 679 – 6238

Consent to Release Private Health Data

Student's Full Name: _____ Birth date: _____

Parent(s) / Guardian(s) Name: _____

Parent(s) / Guardian(s) Address: _____

I authorize: Anne Grahn MS, RN, PHN, LSN District Nurse District # 332
(School District Name and Person Responsible)

_____
(Address)

Mora MN 55051
(City) (State) (Zip Code)

☐ Release information **to:** ☐ Obtain information **from:** (check either or both boxes, as needed)

_____
(Name, Title)

_____
(Organization)

_____
(Address)

_____
(City) (State) (Zip Code)

The information to be released:

- ☐ Immunizations
- ☐ Health Record
- ☐ Medical Records
- ☐ Teacher, Counselor and Staff Observations
- ☐ Official School Records
- ☐ Special Education Reports
- ☐ Psychological Records
- ☐ Other _____

The purpose for the request: _____

_____

I understand that this authorization takes effect the day I sign it. It expires on a requested date, or no more than one year from the date of my signature. I also understand that I may change or revoke this authorization at any time by sending written notification to Minnetonka Public Schools and that said change or revocation will not affect information previously released according to my consent. In accord with revised federal and state statues, permission of the parent or adult student is no longer required when authorized school personnel request records.

It expires on: _____

_____ Date: _____
(Parent/Guardian signature, or student if age 18 or older)

A pupil's records may be examined at any time by the parent, guardian, or pupil (18 years or older).

Rev. October 2020