Cass Lake-Bena Health Services
AUTHORIZATION FOR MEDICATION ADMINISTRATION

STUDENT NAME:_____ GRADE:_____

DATE OF BIRTH: _____ SCHOOL: _____ SCHOOL YEAR: _____

Parents/Guardians of students requesting prescription/non-prescription medications to be given to their child during school hours by school staff are required to provide the school with the following information:

PRESCRIPTION MEDICATION:

1. Signed parent/guardian consent for each medication every school year.
2. Physician's /licensed prescriber's medication order.
3. Medication must be supplied in the original pharmacy labeled bottle to the school by parent/guardian. Ask for prescription medication to be divided in two bottles at the pharmacy.

NON-PRESCRIPTION MEDICATION:

1. Signed parent consent
2. Medication must be supplied in the original package.

☐ *Please **check box** for **non-prescription medications** and have parent/guardian fill out medication information below.*

Physician/Licensed Prescriber's order for Medication Administration by School Staff

Medication: _____ Dosage: _____

Time: _____ Route: _____ Duration: _____

For the treatment of: _____

Licensed Prescriber Signature: _____ Date: _____

Clinic Address: _____ Phone: _____

Parent/Guardian Authorization

1. I request that the above prescription medication be given during school hours by school personnel as delegated, trained, and supervised by the school nurse and as ordered by my child's physician/licensed provider.
2. I will notify the school of any change in the medication, (i.e. dosage change, medication is stopped, etc.).
3. If medication is non-prescription, this signature also gives permission to administer that medication.
4. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to this medication, medical condition or side effects of this medication.
5. I release Cass Lake-Bena School District from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication as ordered by my child's physician.

_____ _____ _____

Parent/Guardian Signature | Date | Relationship to Student

Accepted by: _____ Date: _____