ISD #4007 ******** NURSE FILE********

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the Health Services Coordinator)

** Before any medication is administered by school personnel this form must be completed and on file with the school health office**

Pupil's name_____ Birth Date_____

School_____ Grade_____ Teacher_____ School Year_____

PHYSICIAN'S ORDER

I have prescribed the following medication for this child and request dosages given during school hours be administered by school personnel.

Medication_____ Dosage_____

Time to be given at school_____ Directions for giving medication_____

Possible side effects _____ Diagnosis for medication_____

Inhalers/Epinephrine auto-injectors: Child has received instruction and permission to self-carry and independently self manage: Yes_____ No_____ If inhaler: with spacer_____ without spacer_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PRINT NAME_____OFFICE PHONE NUMBER:_____

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PARENT/GUARDIAN AUTHORIZATION

FOR PRESCRIPTION MEDICATION:

1. I request the above medication be given to my child during school hours (no after school activities) as ordered by my child's physician, and authorize school personnel to exchange information with my child's physician regarding this medication, medical condition and side effects of this medication.
2. I authorize the Health Services Coordinator/designee to communicate with appropriate school personnel regarding this medication.
3. I will provide this medication in the original, properly labeled pharmacy bottle.
4. Field trips- I give permission for a teacher/school personnel to administer medication on a field trip.
5. I release school personnel from any liability in relation to the administration of this medication at school. I also understand that administration of this medication will not necessarily be done by the Health Services Coordinator/School Nurse.

PARENT GUARDIAN_____ DATE_____

FOR NON-PRESCRIPTION MEDICATIONS:

Medication_____ Purpose for medication_____

Amount & Frequency_____ _____ _____

(Must follow age and weight appropriate directions) *(age)* *(weight)*

1. I request the above medication be given to my child during school hours (no after school activities)
2. I will provide this medication in the original, properly labeled container.
3. I release school personnel from any liability in relation to the administration of this medication at school. I also understand that administration of this medication will not necessarily be done by the Health Services Coordinator/School Nurse.

PARENT/GUARDIAN_____ DATE_____

SCHOOL NURSE/DESIGNEE SIGNATURE_____ DATE_____

Updated Last: 2/10/2022