Form M-3

Cook County Schools Health Office

Alexandria Ermatinger, Registered Nurse

Phone 218.387.2271 ext. 116

Prescription Medications

MEDICAL ORDER AND AUTHORIZATION TO ADMINISTER Permission Form

Student Name: _____ Birthdate: _____

Grade: _____ Teacher: _____

Please list medications that will be needed on the overnight field trip:

Medication	Dose	Route	Medication Form: (ie. pill, insulin, etc.)	Frequency	Time of day	Reason for Medication

***Unless indicated otherwise, start date of medication administration shall be the time this form is recieved and medication <u>has been delivered to the health office, and stop date will be the last date of the school year.</u>**

****Medications can not be administered if we do not have the medication available to us in the school.**
We will do our best to contact the family to have more delivered, but can not give a medication we do not have.

Pharmacy Name: _____ Contact Phone Number: _____

Clinic Name: _____ Clinic Phone Number: _____

Health Care Provider Name: _____ License Number: _____

Health Care Provider Signature: _____ Date: _____

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PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this students health care provider (HCP). I understand I must provide prescritption medications in an original pharmacy container with a current label.
Over-the-counter preparations must be provided in the original, labeled container. A controlled prescription medication must be brought to school by a parent/guardian.

2. I give permission for the school registered nurse, a trained health office assistant or delegate to administer the medications prescrbed to my child.

3. I will immediately notify the school of any change in the medication or Health Care Provider's (HCP) order, dosage change, frequency, or duration of administration.

4. I give permission for this information to be released to school personnel. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.

5. I understand that I can refuse to share this information with other school staff (contact school nurse).

6. I release all school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

ONLY the following persons (name and relationship to student (have permission to drop off AND pick up medication from the school health office:

_____

_____

Parent/Guardian Name _____ Signature: _____

Contact Phone Number _____ Date: _____