Murray County Central – ISD 2169

Dear Parents:

Each student who will be taking medication at school during the school day must have a written order from their physician on file at the school their child attends.

Students should take their medication at home if at all possible. I know that this is not possible in all cases.

The following information is needed from your child's physician in order to provide in school medication dispensing:

- Name of student
- Name of medication (include generic name if applicable)
- Dosage of medication
- Time medication should be taken
- Reason why the medication must be given at school
- Possible side effects of the medication
- Readable signature of the doctor prescribing the medication
- Name and address of the medical facility where the doctor works

I am aware that this may be an inconvenience to you, but it is a policy that must be followed. Your cooperation is greatly appreciated. On the back of this letter you will find the Physicians Order and Parental Consent form for Murray County Central Schools. Please obtain the information needed from your child's physician and send or bring the completed form back to me. Please note that you may even send this letter and the form to your child's doctor and they can send it or fax it back to me at school.

The Physicians Order and Consent Form must be received prior to your child obtaining medication in the school setting.

Thank you for your cooperation and assistance.

Sincerely,

Desirée Haupert CCMA
2420 28th Street
Slayton, MN 56172
Phone – 507-836-6184
FAX 1-507-836-6375
Desiree.Haupert@mcc.mntm.org

Complete form and send or fax to:

Desirée Haupert CCMA
Murray County Central Schools
2420 28th Street
Slayton, MN 56172
FAX 1-507-836-6375

Physicians Order and Parents Consent Form for Giving Medications at Murray County Central Schools

Complete the following information ~ physician's signature is necessary.

Today's date: _____

Student Name: _____ Birthdate _____

Parent/Guardian's Name: _____

Name of Medication: _____

Dosage of Medication: _____

Time medication should be taken: _____

Purpose of medication and why it must be taken during school hours: _____
_____

Possible side effects: _____

- ❖ Physician's signature (must be readable): _____
- ❖ Name and address of medical facility: _____
- ❖ Telephone number/fax number: _____ / _____

Date: _____ **Parental Consent**

(To be completed and signed by the parent/guardian)

I request that the above named medication be given at school or field trips to _____ as prescribed by our physician. I will insure that the medication will be brought to school by an adult. The medication will be in a container labeled by the physician or pharmacist. The label must contain the name of the pharmacy, patient's name, name of prescribing physician, directions or use and date.

Parents/Guardian Signature (must be readable): _____

Date consent form was received at Murray County Central Schools; _____
Consent form was received by: _____