Cuyuna Range Elementary School (grade K-6th)
509 6th Ave. NE
Crosby, MN 56444
Phone: (218) 545-8772
Fax: (218)-545-8858

Crosby/Ironton High School (grade 7th-12th)
711 Poplar Street
Crosby, MN 56441
Phone: (218) 545-8823
Fax: (218)-545-8835

Medication Doctor's Order Form

1. Whenever possible, medications should be given outside school hours under parental/guardian supervision. This includes short term antibiotics ordered two and three times a day.
2. All medication must be in the original container and be clearly marked with the student's name, the medication name, the dosage to be given, and the method of administration. Prescription medications must also include the physician name and the pharmacy name. Parents/guardians should request duplicate containers of medication from the pharmacy when medication is to be given at home and at school. Medication will only be given in a manner consistent with the instructions on the label or a more recent order from the physician.
3. Parents/guardians are encouraged to deliver all medications to the nurse's office. If this cannot be done, arrangements must be made with the nurse or health assistant to arrange an acceptable means of delivery.

Parent/Guardian Authorization

1. I will immediately notify the school of any changes in the medication or if the physician orders a dosage change, change in frequency, or duration of administration.
2. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
3. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
4. Field trips – I give permission for a teacher or designated adult to administer the medication on a field trip, as necessary, following school procedure.
5. I have instructed my child as to the reason and importance for taking this medication and have informed my child of the time the medication is to be taken.
6. I request that the school nurse, or other trained and authorized personnel, give medication as prescribed by a physician to the child named below. I release all school personnel, ISD#182 and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

Name of Student: ______________________________ D.O.B: ________________

Name of School: ______________________________ Teacher/Grade:______________

Name of Parent/Guardian: ___________________________ Phone # :_________________

Signature of Parent/Guardian: _____________________________ Date: ___/___/___

To be completed by Physician/Healthcare Provider:

ICD-10 code:____

Medication to be given:____

Dosage:________________Time of administration: ________________________________

Route of administration:______________ Dates to be given: 9/6/22 - 05/26/23 (22/23 school year)

Potential side effects: ____

Physician's Signature: ____ Date: ___/___/___

Physician's Printed Name:____ Phone #: ______________

School Nurse Approval (signature): _______________________________ Date: ___/___/_____