



First Baptist School

Rosemount, Minnesota

Authorization for Administration of Prescription Medication at School

Student Name _____ Date of Birth _____

Grade _____ School Year _____ Allergies _____

Medication Order						
This section must be completed by the health care provider when medication is prescribed for more than two weeks OR is a controlled medication.						
Medication Name	Controlled Med Y/N	ICD 10/ Diagnosis	Dose	Time	Route	Possible side effects
1.						
2.						
3.						

Other considerations/directions _____

signature of healthcare provider

printed name of healthcare provider

date

clinic name

clinic phone

clinic fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as prescribed by my child's health care provider.
2. I will notify the school of any change in the medication(s), i.e., dosage change, medication is stopped, etc.
3. I give permission for the medication(s) to be given by trained school personnel when delegated by the school nurse in her/his absence.
4. I release school personnel from liability in the event adverse reactions result from taking the medication.
5. I understand that I must supply this medication in an original labeled prescription bottle.
6. I understand that I am required to retrieve controlled substances when requested by the school.
7. I designate the school as an authorized entity to transport non-controlled substances for purposes of destruction if unused amounts remain in the possession of school personnel.
8. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the use of the medication(s).
9. I give permission for the nurse and health care provider to release information from each other related to the above medication(s) and medical condition(s). Health records, in the possession of the school, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA), but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

This authorization takes effect the day that I sign it and expires one year from the date of my signature. Legally I may refuse to sign this authorization. I understand that this authorization may be revoked at any time by sending a written notice to the nurse. If I refuse to sign, or revoke authorization, these services may not be provided at school.

parent/guardian signature

date

relationship to student

phone number