HOPKINS PUBLIC SCHOOLS
HEALTH SERVICES

Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission. For over-the-counter medications parental signature is required. For prescription medication, parental and the child's Physician/Licensed Prescriber's signature is required every school year.

Student:_____ Birth date:_____ Grade:_____

School:_____ School year:_____

Allergies:_____

Medical Diagnosis	ICD-10-CM Code	Medication	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						

Start date: _____ Stop date: _____

(**Authorization expires at the end of the school year**)

_____ _____ _____
Signature of Physician/Licensed Prescriber Print name of Physician/Licensed Prescriber Date

_____ _____ _____
Clinic address Phone Fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
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 school personnel as delegated, trained, and supervised by the school nurse.
4. This consent may be revoked at any time, by contacting the licensed school nurse.

NOTE: Medication must be supplied in original/prescription bottle.

Permission for Release of Information

5. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
6. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
7. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

_____
Parent/Guardian signature Date Relationship to Student

Please return to: _____ Phone:_____ Fax:_____
(Licensed School Nurse)

Updated 6/6/17/MJM