# Community Christian School

## Authorization for ADMINISTRATION OF MEDICATION

A signed MD order is required for administration of medication at school.

| STUDENT INFORMATION | | | |
|---|---|---|---|
| Student Name | DOB | Grade | School Year 25-26 |
| Medical Condition(s) | | Known Allergies | |

| CONTACT INFORMATION | | |
|---|---|---|
| Parent/Guardian Name | Phone | Cell |
| Parent/Guardian Name | Phone | Cell |

| MEDICATION INFORMATION | | | |
|---|---|---|---|
| **Medication** | Dose 6mL | Route Oral | Frequency |
| Diagnosis/Reason for this medication | | | END DATE |
| **Medication** | Dose | Route | Frequency |
| Diagnosis/Reason for this medication | | | END DATE |
| **Medication** | Dose | Route | Frequency |
| Diagnosis/Reason for this medication | | | END DATE |
| **Medication** | Dose | Route | Frequency |
| Diagnosis/Reason for this medication | | | END DATE |

**NOTE:**

***All prescribed medication** must be brought to school by the parent/guardian in the original container. Prescription medication must be labeled for the student by a pharmacist in accordance with law, and must be administered in a manner consistent with the instruction on the label. **Pharmacies will divide medication in two labeled bottles, one for home and one for school, upon request.**

* **Over-the-Counter (OTC) medications** must come to the school health office in its original container.

**Please contact Annette Sietsema, LSN/RN at 320-295-1621 if you have any questions**

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| PRESCRIBING HEALTH PROFESSIONAL<br>*Complete this section for both PRESCRIPTION and OVER-THE-COUNTER MEDICATION* | |
|---|---|
| **Signature** | Date |
| Printed Name | Clinic |
| Phone | FAX 320-231-6709 |

**If this RX is an MDI (Inhaler) and the student is at least 7 years old or for an, EPI-PEN and the student is at least 12 years old please complete the following:**

**Student should carry and may self administer his/her inhaler**
**Student should carry and may self-administer his/her epi-pen**
**Student should carry and may self-administer his/her** _____
**Other comments:** _____

**Section 1: Parental Request for Administration of Medication**

- I request that the medication and/or treatment specified on this form be given during school hours as ordered by the Physician/licensed prescriber.
- I release school personnel from liability in the event adverse reactions) result from the medication and/or treatment
- I give permission for the medication/treatment to be given by designated school personnel
- I understand that school personnel cannot administer prescribed medication or treatment without authorization from my child's physician/licensed prescriber AND with my permission.
- I will immediately notify the school health office of any changes in the health profession's order, dose change, frequency and/or duration of administration.
- I give permission for school staff to administer the medication on a field trip, as necessary and according to school policy
  ☐ **YES** ☐ **NO**
- **DISPOSAL OF MEDICATIONS–**ALL unused, discontinued, or outdated medications shall be returned to the parent/legal guardian. IF the parent/guardian does not pick up these medications at the end of the school year or as otherwise requested, the medication will be disposed of according to school policy.

**Section 2: Permission for Release of Information Check all that are agreed upon by parent**

- I understand that school personnel will share medical and/or prescription information with emergency responders, if they are called to provide care for my child.
- I give permission for the school personnel to communicate with my child's teachers and other employees that need to know about his/her health condition and the action of the medication/treatment and potential side effects.
- I give permission for the school nurse to consult (both verbally and in writing) with my child's physician/licensed prescriber regarding any questions that arise related to the medical condition and/or medication/treatment being used to treat the condition.

**Please sign below to indicate your permission to administer medication AND your permission to release information as indicated by your check-marks above.**

| PARENT/GUARDIAN AUTHORIZATION | |
|---|---|
| Print Name | Date |
| Signature | |

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