

REDWOOD COUNTY PUBLIC HEALTH SERVICE
266 E BRIDGE STREET ♦ REDWOOD FALLS, MN 56283
PHONE 507/637-4041 ♦ FAX 507/637-4046

WEBSITE: http://www.co.redwood.mn.us/County_Departments/Public_Health/public_health.htm

MEDICATION AUTHORIZATION FORM

School: _____

LAST NAME: _____ FIRST NAME: _____ Date of Birth: _____ Grade: _____

DIAGNOSIS/reason for medication: _____ Medical Provider: _____

MEDICATION: _____ ALLERGIES (FOODS OR MEDICINES):

DOSAGE/ROUTE: _____ NO

TIME/FREQUENCY: _____ YES & List: _____

DATES COVERED BY ORDER: Begin medication _____ Stop medication: _____

1. I request that the above medication be given during the school day.
2. I release school personnel from any liability in relation to this request when the medication is given as directed above.
3. I authorize the prescriber and school nurse to exchange information when questions arise with regard to this medication or the condition being treated by this medication.
4. I give permission for the nurse to communicate with school & support staff, as necessary, about the action and side effects of this medication.
5. I give permission for the assigned teacher/responsible adult to administer this medication on a field trip, as necessary, following school procedure.

* PARENT/GUARDIAN SIGNATURE: _____ Date _____ Phone (Home) _____ (W) _____
(Cell) _____

MEDICAL PROVIDER AUTHORIZATION (If applicable):

Please if student is both capable & responsible for SELF-ADMINISTERING this medication: (subject to school policy)

No Yes Phone _____

* MD/PA/NP Signature _____ Date _____ Fax _____

MEDICATION POLICY

- School District policy states that medication may not be given to a student unless a written request from the parent is received. Each student will need their own form for each medication to be given.
- **Prescription** medication must be in a properly labeled bottle including the student's name, physician and name, dose and route of the medication to be given.
- **Non-prescription** medication must be in the original labeled bottle & age appropriate for student. No physician signature is required unless there are indications to do so.

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RN-PHN Signature _____ Date _____