Minnesota Valley Lutheran High School

45638-561st Ave.

New Ulm, MN 56073

507-354-6851 or fax 507-354-6854

MEDICATION AUTHORIZATION FORM

Medication EXP: _____

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.

(Cell) _____ (Work) _____

*PARENT/GUARDIAN SIGNATURE: _____ Date _____ PHONE (Home) _____

MEDICAL PROVIDER AUTHORIZATION (if applicable):

Is student 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.