LUVERNE PUBLIC SCHOOLS
709 North Kniss
Luverne, MN 56156
Telephone (507) 283-4491
FAX (507) 283-9681
www.isd2184.net

PRESCRIPTION MEDICATION DURING THE SCHOOL DAY

Parents of students requesting that medication be administered during the school hours by the school nurse or his/her designee are requested to provide for the school:

1) **Physician's signature on order**,
2) **Parental release signature**,
3) **Medication supplied in the original pharmacy container**.

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I have prescribed the following medication for this student and request doses be given during the school day.

Student Name_____

Grade_____ Homeroom Teacher_____

Medication_____

Dosage_____ Route: by mouth_____ eye drops: right_____ left_____
inhaler_____ ear drops: right_____ left_____
apply to skin_____ nebulizer _____

Time given _____AM _____PM Beginning_____ Ending_____
_____Noon (All authorizations expire at the end of the school year.)

Purpose or reasons medication needed:_____

Possible side effects:_____Allergies:_____

What other OTC or prescription medication is the student taking at home?_____

Date:_____ Physician_____Phone:_____
Signature

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication.(ex: dosage change, medication is discontinued)
4. I give permission for the school nurse to consult with the above names student's physician/licensed prescriber regarding any questions that arise with regard to the medication or medical condition being treated by the medication.
5. I give permission for the school nurse to communicate with the student's teachers about the action and side effect of the medication.
6. I give permission for the medication to be given by the designated personnel as delegated by the school nurse.

Date:_____ Parent or Guardian_____ Phone:_____