Goodhue County Education District #6051

School Medication Physician Order and Parent Authorization Form

NAME: _____ Birthdate: _____
(Last) (First) (Middle)

SCHOOL: _____ GRADE: _____

PHYSICIAN'S ORDER

I hereby request and authorize you to give:

Medication: _____ Dosage: _____ Time: _____ Duration: _____

1 _____

2 _____

3 _____

Allergies: _____

Diagnosis/Medical Reason for the Medication: _____

Other Medications this student is taking: _____

_____

Physician's Signature: _____ Today's Date: _____

PRINT Physician's Name: _____ Phone #: _____

Clinic Name & Address: _____ Fax #: _____

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 that medication to be given on field trips, as prescribed.
2) I release school personnel from any liability in relation to this request when the medication is given as ordered.
3) I will notify the school of any changes in the medication (dosage change, medication is discontinued, etc.)
4) I give permission for the nurse to communicate with the student's teachers about the student's health condition and the action and side effects of this medication.
5) I give permission for the nurse to consult with the above names student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6) I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

Signature of Parent/ Guardian: _____ Date: _____

Relationship to Student: _____ Daytime Phone #: _____