Perham-Dent Public Schools – ISD #549

Sue Seip RN, LSN – PWMS (346-1758)

Authorization for Administration of Non-Prescription Medication

Student Name: _____ Date of Birth: _____

Parent/Guardian:_____

Teacher/Grade_____ School _____

(A physicians order may be requested upon the Licensed School Nurses' discretion.)
To School Personnel:

I hereby request and authorize you to administer the following non-prescription medication to be given during the school day to be administered by the School Nurse or school personnel that has been delegated by the School Nurse.

MEDICATION	DOSAGE	TIME	DURATION
1.			
2.			

Reason for medication: _____

Other medication student is taking: _____

Allergies: _____

Student's Physician: _____

Clinic_____ Phone #_____

Parent/Guardian Authorization

1. I request the above medication be given to my child during school hours.
2. I understand that I must provide this medication in the original labeled container.
3. I will immediately notify the school of any changes in the medication dosage, frequency, or duration of administration.
4. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
5. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
6. I have instructed my child as to the reason and importance for taking this medication and have informed my child of the time the medication is to be taken.
7. I release all school personnel, I.S.D. #549 and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

PARENT/GUARDIAN: