Northfield
Public Schools I.S.D. 659 MINNESOTA

School Medication/Physician Order & Parent Authorization Form

Name of student_____ **DOB**_____

School_____ **Date**_____

PHYSICIANS ORDER:

I hereby request and authorize you to give:

Medication	**Dosage**	**Time given**	**Duration**

Diagnosis/medical reason for medication:_____
Other medications this student is taking:_____
Side effects:_____

Physician signature_____ **Date**_____

Print Physician 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.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. We will notify the school of any change in the medication (dosage change, medication is discontinued before the time stated in the Dr. order)
4. I give permission for the school nurse to communicate with teachers/staff about the action and side effects of this medication.
5. I give permission for the school nurse to consult with the above named physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6. **FIELD TRIPS:** I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

Signature of Parent/Guardian_____ **Date**_____

Relationship to student_____ **Phone#**_____