Trinity Lutheran School

500 West Church Street
Belle Plaine, Minnesota 56011
952-873-6320

Parents of pupils requesting that medication be administered during school hours must provide for the school the following items: the Physicianøs Order and signature, parent/guardian signature, and medication in the original container (ask for prescription medication to be divided into two bottles completely labeledô one for home and one for school.)

Student Name: ____ Birthdate: _____/_____/_____

Condition	Medication	Strength	Dose	Time	Method	Possible Side Effects

Grade: _________ Teacher: ____

Other considerations: ____

Start Date: _____________ Stop Date: ____________ (All authorizations expire at the end of the school year.)

_____ Student is knowledgeable about the medication and how to administer it.
_____ Student has the skills to safely possess and use an inhaler.
_____ Student may self-administer the medication. (Not applicable for controlled substances.)

____ ____
Print or type name of physician/licensed practitioner Physicianøs signature

____ ______________________ ____________________
Clinic Address Phone Number Date

Parent/Guardian Authorization

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

________ My child may self-administer his/her medication. (Not applicable for controlled substances such as Ritalin, Dexedrine, Codeine, etc.)

________________ ______________________________ ________________________
Date Parent/guardian signature Relationship to student