

# BOLD Public Schools

I.S.D. # 2534 Bird Island-Olivia-Lake Lillian School District

## Prescription Medication Medical Order for Medication and Parent/Guardian Authorization Form

(To be renewed annually)

Medications should be administered at home under the supervision of the parent/guardian whenever possible. Before any prescription medication will be given by school staff, a form signed by the physician and parent/guardian of the student must be on file with the school. Prescription medications must be provided in an original pharmacy container with a current label.

STUDENT: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

SCHOOL : \_\_\_\_\_ GRADE: \_\_\_\_\_

### PHYSICIAN/ LICENSED PRESCRIBER'S ORDER

Medication	Dosage	Frequency	Duration (One Year)

Condition for which prescribed: \_\_\_\_\_

Allergies: (food or medications) \_\_\_ Yes \_\_\_ No Please List: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

This student is both capable and responsible for **self-administering** this medication (subject to school policy):

\_\_\_ No \_\_\_ Yes, supervised \_\_\_ Yes, unsupervised

In the event of missed doses at home this student may take missed dose at school with parent direction. \_\_\_ YES \_\_\_ NO

Physician or Authorized Prescriber: (Please print) \_\_\_\_\_

Clinic / Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Parent/Guardian Authorization

- I request that the above medication be given at school as prescribed by the physician / licensed prescriber.
- I give permission for the school nurse to consult with the above named students' physician/licensed prescriber regarding questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication.
- I release school personnel from any liability in the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse.
- I understand that to promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.

Physician and I agree that my child needs medication on field trips. \_\_\_ Yes \_\_\_ No

Parent / Guardian Signature: (Required) \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Return this form to the high school office or Fax 320-523-5410 / Attn: Tabitha**