

# School Medication/Physician Order & Parent Authorization Form

**PRAIRIE CREEK  
COMMUNITY SCHOOL**  
507-645-9640 fax 507-645-8234

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# \_\_\_\_\_