Pequot Lakes School
Eagle View Elementary
Nurse's Office phone: (218) 562-6105, FAX :(218) 562-6106

Authorization for Administration of Medication at School

Name of Student: _____Birth Date:_____

School: _____ School Year: **2025-2026** Grade: _____

Medical Condition ICD-10 Code	Medication	Strength	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						

Other Considerations / Directions: _____

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 Prescriber Physician's / Licensed Prescriber's 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 this student's physician / licensed prescriber. I also request the medication(s) be given on field trips by a staff member as delegated by the school nurse.
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), (ex: dosage change, medication is discontinued, etc.)
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the school nurse to consult with the above-named student's 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 sent home with my student on the last day of school. (Any controlled medications MUST BE PICKED UP by parent or guardian at the end of the year. Health office does not store any medications over the summer, and does not destroy unwanted medications.

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

_____ _____ _____
Date Parent/Guardian Signature Relationship to Student

NOTE: Medication is to be supplied in the original / prescription bottle.