

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Minot Public School - Jim Hill Middle School procedure requires a physician's or dentist's written order and parents or guardian's authorization for administration of medication. This includes prescription and over the counter medications. Medications must be in a properly labeled pharmacy prepared container or in the original bottle.

Name of Student: _____

Date of Birth: _____

PHYSICIAN'S OR DENTIST'S ORDER:

Medication: _____ Dose: _____ Route: _____

Time/Frequency: _____

Reason for Medication: _____

Special Instructions: _____

Side Effects: _____

PHYSICIAN'S OR DENTIST'S NAME: _____

ADDRESS: _____ TELEPHONE #: _____

Physician's or Dentist's Signature: _____

Date: _____

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AUTHORIZATION BY PARENT/GUARDIAN

Date: _____

To School Personal:

I hereby request that the above medication, ordered by the physician/dentist for my child,

_____, be administered by authorized personnel. I understand I must

supply the school with the student's medication in the original container or properly labeled pharmacy

container. I understand that any remaining medication will be destroyed if it is not picked up by the last day of

school. I also give the nurse or principal permission to contact my student's physician.

Parent Signature: _____

Relationship to student: _____