NORTHLAND PINES SCHOOL DISTRICT

Medication Administration Consent Form

FAX Numbers:

7-12 Campus: (715)479-5808
Eagle River Elementary: (715)477-6263
St. Germain Campus: (715)542-3660
Land O Lakes Campus: (715)547-3903

Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Medication Name: _____

Dosage (mL, mg, etc.): _____ Student's weight: _____ lbs.

Route: _____ Time(s) to be given: _____ Expiration Date: _____

Entire School Year: _____ **OR** Start Date: _____ End Date: _____

Reason for Medication: _____

Possible Side Effects: _____

PARENT/GUARDIAN:

The school personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the Northland Pines School District, its employees and agents who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school. I hereby give my permission for the School District of Northland Pines to contact the physician/health care provider listed below with questions as they arise regarding the administration of this medication. I shall pick up unused portions of this medication within three (3) days of completion of the school year or when discontinued. I agree to notify the school in writing at the termination of this request.

Signature of Parent/Guardian: _____ Date: _____

* Over the Counter medication **must** come in its original, small container, with expiration date evident and child's name easily readable on container.

FOR INHALED OR INJECTED MEDICATION ONLY:

This student is both capable and responsible for self-administering this medication:

____ Yes - Supervised ____ Yes - Unsupervised ____ No - reason/restrictions: _____

This student may carry their inhaler/injectable medication while at school:

____ Yes _____ No

PRESCRIBING PRACTITIONER:

Prescribing practitioner authorization is required for all medications that are prescribed, non-FDA approved or for dosages that exceed the manufacturer's recommendations. The prescribing practitioner whose signature follows hereby authorizes school personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures.

Practitioner's Name (print): _____ Date: _____

Practitioner's Signature: _____ Phone number: _____

Prescription Medication Verification Between Parent and Staff - To be filled out when dropping off and picking up.

Date	Inventory	Signature	Signature