英華 YINGHUA ACADEMY
1616 Buchanan St NE, Minneapolis, MN 55413 phone: 612.788.9095 fax: 612.788.9079

# Medication Authorization Form 2016-17

**Student Name:**_____ **DOB:**_____ **Grade/Section:**_____

Parents/Guardians asking school staff to give medications to their child must provide written permission **each school year that has been signed by both the parent/guardian and a licensed health care provider**, including over-the-counter medications, herbals, and supplements.

**** Any student with a health condition that could result in an emergency: asthma, seizures, severe allergies, etc., must also submit an emergency action plan provided by their clinic or downloaded from the health office webpage.****

**Directions:** Please fill out one form per medication. All medications must be supplied to the health office in original container with pharmacy label and transported by an adult. **Medications without completed authorization forms cannot be given.**

## Physician/Licensed Prescriber Section

I have prescribed and authorized the following medication to be administered by the appropriate trained school personnel:

**Medication:**_____

**Dose/Route:**_____

**Frequency:**_____

**Reason for medication:** _____

_____

**Special Instructions:**_____

_____

**For emergency medications only, (epinephrine injectors, inhalers, etc.) please check one**:

- ☐ After discussion with parent/guardian, I deem this student capable of self-carry and I have explained instructions to the student.
- ☐ After discussion with parent/guardian, this student will **NOT** self-carry their medication.

_____
**Physician Name (printed)**

_____
**Physician Signature** **Date**

_____
**Clinic Name**

_____
**Phone Number** **Fax**

## Parent/Guardian Authorization

1. I request that the medication be given **as ordered** during school hours/field trips by school personnel trained by the school nurse.
2. I will notify the school of any change in the medication and will provide new medication before current medication is expired (expired medication cannot be given).
3. I give permission to both the licensed school nurse and the health care provider listed to consult about any questions regarding the medication or health conditions being treated by the medication.
4. I understand that all medication (except emergency medication) must be kept in the Health Office for the safety of all students.
5. **For emergency medications only (epinephrine injectors, inhalers, etc.)**, after discussion with the health care provider, I agree that my child (**please check all the apply)**:
   - ☐ May **not** self-carry.
   - ☐ **May self-carry and self-administer.**
   - ☐ **May self-carry, but needs assistance to administer.**
   - ☐ **I accept all responsibility in the event that the self-carry medication is lost or misused.**
6. **I release school personnel from any liability in the administration of this medication.**

_____
**Parent/Guardian Signature** **Date**

_____
**Name (printed)** **Phone Number**