英華 YINGHUA ACADEMY

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

Medication Authorization Form

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 the original container with the 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:_____

_____

Please check for emergency medications only (epinephrine injectors, inhalers, etc.):

- ❑ 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. **Please check for emergency medications only (epinephrine injectors, inhalers, etc.)**, after discussion with the health care provider, I agree that my child:
   - ❑ May **not** self-carry.
   - ❑ **May self-carry and self-administer.**
   - ❑ **May self-carry, but needs assistance to administer.**
6. **I accept all responsibility in the event that the self-carry medication is lost or misused.**
7. **I release school personnel from any liability in the administration of this medication.**

_____

Parent/Guardian Signature **Date**

_____

Name (printed) **Phone Number**