NORTHLAND PINES SCHOOL DISTRICT

Medication Administration Consent Form

FAX Numbers:

7-12 Campus: (715)230-5040
Eagle River Elementary: (715)230-5028

St. Germain Campus: (715)230-5009
Land O Lakes Campus: (715)230-5025

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