



MINNEHAHA
ACADEMY

Authorization for Administration of Medication

Overnight Field Trip / Retreat / Cultural Field Experience – Effective From (Date) _____ to _____

Student: _____ Grade: _____ Birth Date: _____ School Year: _____

Allergies: _____

Physician/licensed healthcare provider orders for administration of medication by school staff:

Medical Condition	Medication/Treatment	Dose and Route	Time/Dates Effective	Side Effects

Parents and Doctor must sign off if ok for student to self-carry and administer prescription medication. **Any controlled prescription medication will be with the trip leader/coach/school personnel.**

Initial Here If: Student may self-carry/administer inhaler, epi-pen, or other emergency medication and non-controlled prescription medication.

_____ Licensed Prescriber

_____ Initials Parent Initials

**Medication MUST be provided in the original, CURRENT manufacturer or prescription container.
All medication authorizations expire at the end of each school year.**

Physician Signature: _____ Date: _____

Physician Name (print): _____ Clinic Name: _____

Phone: _____ Fax: _____

Parent/Guardian Authorization

1. I request that the above medications and/or treatments be given during school hours as ordered by my student’s physician or licensed healthcare provider. I also request the medication to be given on field trips, as prescribed.
2. I will notify the school of any changes in medication(s). I will provide the school with a new, signed copy of this form to reflect those changes.
3. I give permission for the medication(s) to be given to my student by school personnel as delegated, trained, and supervised by the school nurse. School personnel may include teachers, qualified parent volunteers, and school support staff.
4. I understand that legally, I may refuse to sign for the medication. If I refuse to sign the authorization, Minnehaha Academy will not be able to administer the medication to my student at school.
5. This authorization may be revoked at any time, by sending a written notice to the school nurse.
6. By signing below I also give the school nurse permission to communicate with school staff regarding my child’s medical condition and treatment.
7. I give the school nurse permission to consult with my child’s physician/licensed healthcare provider regarding the above medical condition and treatment.
8. I give permission for the physician/licensed healthcare prescriber to release information related to the above medications and medical conditions to the school nurse.
9. I acknowledge that it is my son/daughter’s responsibility to not distribute their medications to other students. If they do, they could be held responsible legally as well as by Minnehaha Academy.

Parent/Guardian Signature: _____ Relationship to Student: _____

Parent/Guardian Name (print): _____ Date: _____

Phone 1: _____ Phone 2: _____