H.1: Burnsville/Eagan/Savage Schools Medication/Treatment Authorization Form

Sample form

Burnsville/Eagan/Savage Schools
Medication/Treatment Authorization Form
(Has been determined HIPAA compliant)
(Parent and Licensed Prescriber/Physician)

Name:

DOB:

MR#: HCL#:

Label or Addressograph

PARENT – PLEASE COMPLETE

Parent(s)/Guardian: Communication between the medical community and school(s) provides for positive health outcomes for students, families and community. Completion of this form and returning to school nurse at your student's school enhances coordination of services and promotes an optimal learning environment.

☐ Please fax this form to my students school nurse. Fax Number: _____
☐ I will provide this form to the school nurse at _____(please specify school) for the _____ (please specify year) school year.

1. I request that the medication(s) and/or treatment(s)/procedure(s) specified on this form be given during school hours as ordered by this student's physician/licensed prescriber.
2. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).
3. I will provide the school with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)
4. I give permission for the school nurse to communicate with the student's teachers about my student's health condition (s) and the action of the medication(s) and/or treatment(s)/procedure(s).
5. I give permission for the school nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.
6. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designed personnel as delegated by the school nurse.
7. I understand that school health personnel cannot administer the medication(s)/treatment(s)/procedures(s) indicated on this form without authorization from my student's physician/licensed prescriber.

Additional Information:

_____ _____ _____
Date Parent/Legal Guardian Signature Relationship to Student

Endorsed by the Minnesota Academy of Family Practitioners (MAFP) and the American Academy of Pediatrics, Minnesota Chapter.

Student's Name: _____ DOB: ____/____/_____

School/Provider Communication Record
Medication/Treatment Authorization Form
PHYSICIAN/LICENSED PRESCRIBER – PLEASE COMPLETE

Diagnosis/Significant Findings:

History:

ALLERGIES:

Medication Required During School Hours					
Medical Condition	Medication	Strength	Time	Route	Possible Side Effects
1.					
2.					
3.					

****Medication is to be supplied in the original manufacturer or prescription container.****

Treatments/Procedures Required During School Hours (e.g., Peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes)			
Medical Condition	Treatment/Procedure	Time(s)/Frequency	Special Instruction
1.			
2.			

ADDITIONAL INFORMATION:

☐ Student may carry/self administer his/her inhaler.
☐ Student may carry/self administer his/her epi-pen injector.
☐ Student may carry/self administer _____(*Please identify*)
☐ Return to school with NO limitations on ___/___/___.
☐ REST AT HOME through ___/___/___ or until next scheduled visit.
☐ MODIFY the following activities during the school day through ___/___/___ or until next visit.

☐ Physical Education ☐ Ambulation
☐ Sports ☐ Diet

Please specify:

_____ _____ _____
Date Print Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____ _____
Clinic Name and Address Telephone Number

Adapted from Burnsville/Eagan/Savage School District and the Park-Nicollet Healthy Community Initiative. Burnsville, MN (2002-3).