WADENA-DEER CREEK SCHOOLS ISD #2155
Authorization for Administration of Medication(s)

☐ PRESCRIPTION MEDICATION ☐ OVER THE COUNTER MEDICATION

Student Name: ______________________________ DOB: ______________
Parent/Guardian(s): ______________________________ Grade: ______________

MEDICATION	STRENGTH	DOSE	TIME	ROUTE	REASON

I have prescribed the following medication for this student and request the medication(s) to be given during school, to be administered by the school nurse or school personnel that have been delegated to administer medication(s). Other directions: ______________________________

PHYSICIAN: ______________________ **PHYSICIAN SIGNATURE**: ______________________
CLINIC: ______________________________ **ICD-10 CODE:** ______________________
Phone # ______________________ **Fax #** ______________________ **Date:** ______________________

- ✔ Physician signature REQUIRED for ALL PRESCRIPTION MEDICATIONS.
- ✔ Physician signature for over the counter medication will be requested by the nurse if needed.

Parent/Guardian Authorization

1. I request the above medication be given to my child during school hours, as ordered by a physician/licensed prescriber or over the counter medication authorized by myself.
2. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse. I also request the medication(s) be given on field trips, as prescribed.
3. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
4. I will notify the school of any change in the medication(s), such as dosage change, discontinuation of medications(s).
5. I understand I must provide this medication in a properly labeled pharmacy bottle, or original over the counter bottle/packaging.
6. I give permission for school personnel to communicate with the teachers, physician/licensed prescriber about the medications, side effects, action of the medication and any questions that should arise regarding the students medication(s)
7. I give my child permission to self-administer the medication above. My child has the skills and the knowledge to safely possess the medication above. (inhalers, Epi-pens, Insulin, diabetic testing supplies) ☐
   Parent Initials: ________

PARENT/GUARDIAN: ______________________________________
Telephone Number: ______________________ **Date:** ______________________

WDC Phone	Elementary Fax	Middle-High School Fax
218-632-2155	218-632-2499	218-632-2399