Wrenshall Public Schools
Health Services Office
Medication Request and Physician Authorization

Student Name: ___________________________________ **Date of Birth**_______________

Name of Medication: ____

Method of Administration:____

Dose of Medication:____

Time to be given in School: ___________________________

Diagnosis and Medical Reason for Medication: ____________________________________

I certify that this student can self-carry and correctly self-administer as directed his/her inhaler (INHALER USE ONLY) ____YES _____NO

Physician Signature: ____________________________________ **Date:** __________
(Medication orders must be renewed at the beginning of each school year.)

Clinic Name: _____________________________________

Physician Telephone #: __________________ Clinic Address: __________________________

Clinic Fax #: ________________________

Wrenshall Public Schools - Phone #: 218-384-4274 Fax #: 218-384-4293

Parent/Guardian Authorization

1. I request the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school health service office of any change in the medication (dose change, discontinuation of the medication, etc.).
4. I give permission for the school health service office to communicate with school staff about the action and side effects of this medication on a need to know basis.
5. I give permission for the school health service office to consult verbally or in written fashion with the above named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6. Field Trips: I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary following school protocol.

Parent/Guardian Signature: __________________________________ Date: _____________