Trinity School at River Ridge
601 River Ridge Parkway
Eagan, MN 55121-2499
TEL: 651-789-2890 FAX: 651-789-2891

Authorization for Administration of Prescription Medication at School

Student_____DOB_____Grade_____School Yr_____

School_____ Allergies_____

NOTE: Medication must be supplied in original labeled prescription bottle.
***No narcotic pain medication will be administered during the school day unless authorized by a physician.**

Medication	Medical condition	Dose	Time	Route	Possible side effects
1.					
2.					
3.					

other considerations/directions_____

_____ _____ _____
signature of physician/licensed prescriber print name of physician/licensed prescriber date

_____ _____ _____
clinic name clinic phone clinic fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my student's physician/licensed prescriber. I also request the medication(s) be given on field trips as prescribed.
2. I will notify the school of any change in the medication(s), i.e., dosage change, medication is stopped, etc.
3. I give permission for the medication(s) to be given by trained school personnel when delegated by the school nurse in her/his absence.
4. I release school personnel from liability in the event adverse reactions result from taking the medication.
5. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

_____
parent/guardian signature date relationship to student

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
2. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

_____
parent/guardian signature date relationship to student

Return to Louise Schwab, LSN phone 651-789-2890 ext223 fax 651-789-2891
RN, Licensed School Nurse