Medication Consent Form

Mountain Iron-Buhl School
8659 Unity Drive
Mountain Iron, MN 55768
Phone 218-735- 8271
Fax: 218 -735-8982

School Year _____
Grade _____

Student _____ Date of Birth _____

Parent/Guardian _____ Home Phone _____

Phone Number of Parent/Guardian during school hours _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that medication be given during school hours as ordered by this student's prescriber.
2. I release school personnel from any liability in relation to this request when medication is given as ordered.
3. I will notify the school of any change in medication such as dosage changes, time changes or discontinuation and obtain the appropriate MD order.
4. I give permission for the school nurse to communicate with school staff about the action and side effects of the medication and the condition for which the medication is prescribed.
5. I give permission for the school nurse to consult the above named student's prescriber 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 or other responsible adult to dispense the medication on a field trip if necessary.
7. I agree to provide prescription medication in a container labeled by the pharmacy with the current prescription number and prescription date or in the original container for over-the-counter medications.

Signature of parent/guardian _____ Date _____

Relationship to student _____ Daytime Phone No. _____

PRESCRIBER'S ORDER

I hereby request and authorize you to give:

	Medication	Dose/Route	Time of Day
1.			
2.			
3.			

Diagnosis/Medical reason for medication: _____

ICD 10 CODE: _____

Other medications this student is taking: _____

Other recommendations/UNUSUAL side effects:

Prescriber's Signature _____ Today's date: _____

Print Prescriber's Name _____ Phone No _____
Clinic Name & Address _____ Fax No. _____