Medication Request

300 17th Street North, Moorhead, MN 56560 • Phone: 218-236-0500 • Fax: 218-236-7301

All prescription medication must have a doctor's instructions and signature on this form.
All over-the-counter medication needs only a parent signature.

Student's Name (Last, First) _____ Grade/Teacher _____ Date _____

To administer any medication the school must have **all** the following:

- parent signed and dated authorization to administer the medication
- **unexpired** medication in its **original labeled container** as dispensed or the manufacturer's container
- medication label includes the student's name, name of the medication, directions for use
- Licensed Prescriber Signature, date and instruction on all prescription medication
- Annual renewal of authorization and immediate notification, in writing, of changes

Medication _____ Dosage _____ Time to Administer _____

☐ Oral ☐ Inhaled ☐ Topical ☐ Eye ☐ Ear ☐ Nebulized ☐ Other:_____

Administration Instruction: _____

_____

Diagnosis: _____

☐ STUDENT IS KNOWLEDGEABLE ABOUT THIS MEDICATION & MAY SELF-ADMINISTER

Prescriber Information

Licensed Prescriber Name and Clinic (please print) _____ Date _____

Licensed Prescriber Signature _____ Emergency Phone _____

Parent Information

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or non-prescription instructions and record maintained. The student has experienced no serious previous side effects from this medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. I agree to provide safe delivery of medication to and from school and pick up remaining medication or it will be properly destroyed. All students are responsible to go to the health office for medication administration.

Parent Name _____ Phone _____

Parent Signature _____ Date _____