Medication Authorization Form

Barnesville Public Schools

PO Box 189, Barnesville, MN 56514
Barnesville High School – Phone: (218) 354-2228 - Fax: (218) 354-2305
Atkinson Elementary School – Phone: (218) 354-2300 – Fax: (218) 354-7797
www.barnesville.k12.mn.us

Student Name **Birth date** **Grade** **Date**

SCHOOL MEDICATIONS ARE ADMINISTERED FOLLOWING THESE GUIDELINES:

- Parent has signed and dated authorization to administer the medication.
- Medication comes to the school in PHARMACY labeled container or the MANUFACTURER'S labeled container. Medication will ONLY be accepted in one of these two forms!
- The medication label contains the student name, medication, dosage, directions for use, and date.
- Immediate notification of any changes and authorization renewed annually.

Medication **Dosage** **Route** **Time given at school**

Instructions/side effects/restrictions **Diagnosis**

Printed Name **Licensed Prescriber Signature** **Date**

Licensed Prescriber Address **Phone Number**

Parent Portion

I request this student be given this medication at school and school activities by qualified staff according to instructions. The student has experienced no serious previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that the 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 report to the health office for medication.

In consideration of this authorization made at my request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to, costs and reasonable attorney's fees caused or claimed to be caused or to result from the administration of the above described medications.

Parent/Guardian Signature **Date**

Home Address **Phone Number**