

### Request to Administer Medication at School

*Please complete the following information and return to the student's school.*

Student's Name:		Date of Birth:		Allergies:	
Teacher/Grade:		Parent/Guardian's Name:			Daytime Phone #:
Medication:			Date Started:		Reason for Medication:
Dosage:		Time to be given:		Route of Administration:	Possible Side Effects:
Termination Date:		Special Instructions:			
Health Care Provider's Name:			Clinic Name:		
Clinic Phone #:			Clinic Fax #:		
<ul style="list-style-type: none"> <li>• The school nurse, teacher, or person designated by the school nurse is authorized to administer the above medication as directed.</li> <li>• By signing this form, I authorize the release of my child's health information to appropriate school staff and request that this medication is administered to my child as prescribed.</li> <li>• I authorize the prescriber and the school nurse to exchange information necessary for the safe administration of this medication.</li> <li>• I release school personnel from liability in the event adverse reactions result from medication(s) and/or treatment(s)/procedure(s).</li> </ul>					
Parent/Guardian Signature:				Date:	
Health Care Provider Signature:				Date:	

**No Medications (including Over the Counter meds such as Tylenol) will be given unless Parent and Health Care Provider have given consent.**

**A supply of the properly labeled prescription from the pharmacy should be left at school. It is the parent's responsibility to supply medications for administration to the school and gather the medication supply when discontinued or at the end of the school year (whichever is first). Medications that are left after the school year will be destroyed.**

**Please fax this completed form to:**

Cathedral School  
 Attn: Nanette Widseth RN, PHN, LSN  
 Fax # 218-281-1747, Phone# 218-281-1835