Sleepy Eye Public School Health Services
400 4th Ave SW, Sleepy Eye, MN 56085
Phone: 507-794-7903
Fax: 507-794-5457

ATTN: Both Parent/Guardian **AND** Physician must complete this form to administer medication in school.

Authorization for Giving Medication in School

Student's Full Name_____ Birthdate_____

Parent/Guardian Name _____ Grade _____

_____

To be completed by physician

Name of Medication:_____

Dosage and route of administration:_____

TIme of Administration:_____

Medication to begin (date):_____

Medication to end (date):_____

Purpose of medication and why it's needed during school hours:_____

_____

Possible side effects: Indicate which will be harmful_____

_____

Special Precautions: _____

**Inhalers and Epi-Pens: student has received instructions on use of these medications and may carry Inhaler/Epi-Pen with them to self-administer.

**NOTE: Elementary K- 6 students will not be allowed to carry these with them. They will be kept in the school nurse's office.

Physician's name (printed)_____

Physician's signature:_____

Date:_____

Office Phone number: _____

_____

To be completed by Parent/Guardian

I request medication to be given at school as prescribed by our physician.

Parent Name (printed)_____Parent Signature_____Date:_____

** Note: Medication is to be supplied in the original prescription bottle. Ask for the medication to be divided into two bottles completely labeled one for home and one for school. Label must include name of pharmacy and phone, student's name, name of prescribing physician, directions for use, Medication ID # and date of issue or renewal