

**District 110 – Waconia School District**

**St. Joseph Catholic School**

41 East First Street – Waconia, MN 55387 (952)442-4500 (Health Office ext: 138)

**Parent Request for Medication Administration and Physician Order**

Parents of pupils requesting that medication be administered during school hours must provide for the school:

- Medication in an appropriately labeled container, over the counter medications must be in original container and prescription medications in a prescription bottle.
- Parent/guardian signature.
- A physician signature on form for both prescription and non-prescription.

Ask for prescription medications to be divided into two bottles completely labeled – one for home and one for school. Only when a medication is prescribed to be taken during school hours will a student be given medication at school.

*Please review the “District 110 Medication Policy” on the back of this form.*

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **School:** St. Joseph **Grade:** \_\_\_\_\_

**List any ALLERGIES to medication(s):** \_\_\_\_\_

**Please check/ list below the medication(s) you give permission for your child to take at school.**

**Over -The-Counter Medication(s):**  Children’s Tylenol  Children’s Ibuprofen  Cough Drops  Benadryl  Tums

**Other:** \_\_\_\_\_

**Prescription Medication(s):** \_\_\_\_\_

**Route:**  Oral  Inhaler  Topical  Injection **Dosage:**  Per Weight  As Directed  Other: \_\_\_\_\_

**Time Given/Frequency:** \_\_\_\_\_

**Treatment Of:** \_\_\_\_\_ **Number of tablets sent to school:** \_\_\_\_\_

**Possible Side Effects:** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_ **End Date/Number of days given:** \_\_\_\_\_

I request that this medication be given as indicated above. I understand that administration of medication will not necessarily be done by a Licensed School Nurse or Health Associate, but may be provided by a designated trained school employee. Also, if necessary, the school may request additional information from the physician regarding this illness or medication.

**Sign form below and return it with the medication to the school office.**

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Physician & Clinic Name :** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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