WINONA AREA PUBLIC SCHOOLS
Welcoming All Learners

**STUDENT HEALTH SERVICES**

**1570 Homer Road * Winona, MN 55987**
**507/494-1065 * FAX: 507/494-1067**

# REQUEST FORM FOR ADMINISTRATION OF MEDICATION/PROCEDURE DURING THE SCHOOL DAY

To be completed for EACH prescription medication, nonprescription medication, or procedure.
Consult the school handbook for specific information regarding the district medication policy.

Parents of pupils requesting that medication/procedure be administered during school hours by school staff are required to provide for the school: **1)** physician's order for administration, and **2)** parental request & consent for the administration of medication/procedure.

Student Name:_____ Birthdate:_____

School:_____ Grade:_____

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## Physician Order

### For administration of medication/procedure by school personnel

*The following medication/procedure is to be administered to the student during the school day:*

Medication/Procedure:_____

Dosage:_____ Time/Frequency:_____ Diagnosis:_____

School Year or Effective Dates:_____

For asthma inhalers: Student may carry inhaler? **YES** **NO**

Additional information:_____

Please contact me if the following symptoms occur:_____

Physician Signature:_____ Date:_____

Physician Name:_____ Address:_____ Telephone:_____

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### Parent Request & Consent for administration of medication/procedure by school personnel

- *I request this medication/procedure be administered as prescribed during the school day.*
- *Medication will be supplied in its original properly labeled prescription bottle.*
- *I understand that all medication must be delivered to school by the parent/guardian.*
- *I understand that no medication will be sent home with my child.*
- *This order is in effect for this school year only.*
- *I will notify the school in writing with any changes and obtain a new physician's order.*
- *I authorize school personnel to exchange information with the prescribing physician regarding this medication and the condition for which it is prescribed.*
- *I release school district personnel from any liability claims as a result of the administration of this medication as directed.*

Parent/Guardian Signature:_____ Date:_____

Address:_____ Telephone:_____