MINNESOTA STATE ACADEMIES RESIDENTIAL SCHOOLS
MEDICATION REQUEST AND PHYSICIAN AUTHORIZATION

Student's Name: _____ Date of Birth: _____

To be Completed by a Medical Doctor:

Medical Condition	Medication	Dose	Route	Frequency

Student is knowledgeable about rescue inhaler and may self-administer.

Physician Signature: _____Date:_____
Print Physician's name: _____
Name and Address of Clinic: _____
Telephone Number: _____ Fax Number: _____

PARENT/GUARDIAN AUTHORIZATION:

1. I request that the above medication be given as ordered by this student's physician/licensed prescriber.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the health clinic of any change in the medication, and will provide physician orders documenting the change.
4. I give permission for the school nurse to communicate with school staff about the action and side effects for this medication on a need to know basis.
5. I give permission for the school nurse to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6. I understand I must provide this medication in the **original, properly labeled pharmacy bottle.**
7. Field Trips – I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

Signature of Parent/Guardian: _____ Date: _____