PROVIDER ORDER FOR MEDICATION AND PARENT/GUARDIAN AUTHORIZATION

Student Name: _____ **Date:** ____/____/____

School: _____ **Date of Birth:** ____/____/____

FAX: _____ **Contact Person at School:** _____

Parent/Guardian Name: _____ **Phone:** _____

Provider's Order:

Medication & Dosage	Dose to be given	Time (may administer ½ hour before or after time noted)	Duration

Diagnosis/Reason: _____

Other medications student is taking: _____

Untoward effects that may occur during school hours, and action to taken:

_____

Provider Signature: _____

Susan C. Jenkins, M.D. Jeanne Allen, Psy.D., L.P., APRN, C.N.S.

Jordan Hobbs, APRN, DNP Rachel Beukema, APRN, DNP

Bluestem Center for Child and Family Development

124 Elton Hills Drive NW Ph 507.282.1009
Rochester, MN 55901 Fax 507.282.0932

Parent/Guardian Authorization

1. I request that the above medication be given to my child during school hours as ordered by my child's physician.
2. I will notify the school immediately of changes in dose, medication, frequency, or duration of administration.
3. I give permission for the school contact person to communicate with other school personnel about the action and side effects of the medication.
4. I give permission for the school contact person to consult with this child's health care provider concerning any questions that arise with regard to the medication, diagnosis, or side effects.
5. I release all school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of medication in accordance with these directions.

Parent/Guardian Signature: _____ Date: _____

Reviewed: 5/17/2018