Cedar Mountain Middle/High School
PO Box 188
Morgan, MN 56266
Phone: (507) 249-3900
Fax: (507) 249-3149

Cedar Mountain Public Schools
ISD #2754

Cedar Mountain Elementary
PO Box 38
Franklin, MN 55333
Phone: (507) 557-2251
Fax: (507) 557-2116

Prescription Medication

Medical Order for Medication and Parent/Guardian Authorization Form

Medications should be administered at home under the supervision of the parent/guardian whenever possible. Before any prescription medication will be given by school staff, a form signed by the physician and parent/guardian of the student must be on file with the school. Prescription medications must be provided in an original pharmacy container with a current label.

STUDENT:_____ **BIRTH DATE:**_____

SCHOOL:_____ **GRADE:**_____

PHYSICIAN/ LICENSED PRESCRIBER'S ORDER

Medication	Dosage	Frequency	Duration (One year)

Condition for which prescribed: _____ **ICD-10**_____

Allergies: (food or medications) ____Yes ____No Please List: _____

Possible side effects: _____

This student in 6-12 grade is both capable and responsible for **self-carry** & **self-administering of**: (subject to school policy)

□ **Inhaler** □ **Epi-pen injector** □ **Other (specify)**_____

□ No □ Yes, supervised □ Yes, unsupervised

In the event of missed doses at home this student may take missed dose at school with parent direction. ____**YES** ____**NO**

Physician or Authorized Prescriber: (Please print) _____

Clinic / Address: _____ **Phone #:** _____

Signature:_____ **Date:** _____

Parent/Guardian Authorization

- I request that the above medication be given at school as prescribed by the physician / licensed prescriber.
- I give permission for the school nurse to consult with the above named students' physician/licensed prescriber regarding questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication.
- I release school personnel from any liability in the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse.
- I understand that to promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.

Physician and I agree that my child needs medication on field trips. ___Yes ____No

Parent / Guardian Signature: (Required)_____ **Date:** _____

Work:_____ Cell:_____

Return this form to your school Attn***: School Health Office @ fax # Franklin 507-557-2116 or Morgan 507-249-5887***