BLOOMINGTON Public Schools

Physician Order for Medication and Parent/Guardian Authorization

Health Service
Westwood Elementary School
3701 W. 108th Street
Bloomington, MN 55431
(952) 806-7208 Fax (952) 806-7201

Student: _____ DOB: _____ School year: _____

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					

_____ This student uses ***inhaled medication***, and has been instructed on proper use, side effects and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use as needed according to licensed prescriber's instructions.

_____ This student will keep ***inhaled medication*** in the Health Service Office.

Start date: _____ Stop date: _____
(All authorizations expire at the end of the school year)

_____ _____ _____
Physician Signature Print name of Physician Date

_____ _____ _____
Clinic Address Phone # Fax #

Parent/Guardian Authorization

1. I request that the above medication(s) be given during the school hours as ordered by my child's physician.
2. I give my permission for the medication(s) to be given by school personnel as delegated, trained and supervised by the Registered Nurse/Licensed School Nurse/Health Service Supervisor. I understand that a nurse may not necessarily give medication.
3. The procedure for administering medication on a field trip is different from medication administration during the school day.
4. I will notify the school of any change in the medication(s).
5. This consent may be revoked at any time by giving written or verbal notice to the school health office.
6. I give permission for the school health service staff to consult with my child's physician about any questions regarding the listed medication(s) or medical condition(s) being treated.
7. The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.
8. In consideration of special activity of the School District on behalf of my child, I release all school personnel and the Bloomington Public Schools from any and all liability in the event of any adverse reaction resulting from the use or administration of the medicine.

_____ _____ _____
Parent/guardian signature Relationship to student Date