

MEDICATION/PROCEDURE FORM (SIDE 1)

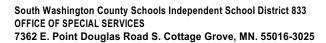
DISTRICT PROCEDURES AND MINNESOTA GUIDELINES REQUIRE THE FOLLOWING:

- Medications which are required during school hours and which the parent/guardian is unable to come and administer, must be administered by a nurse or a designee to whom the Licensed School Nurse has trained and delegated the function of medication administration.
- 2. Medication to be given at school is to be supplied in the original container/prescription bottle. A bottle of the medication should be prepared by the pharmacist, for school, with the appropriate labeling for schooluse.
- 3. Written parental permission and licensed health care provider permission are both required for all prescription medication. A new authorization form must be completed annually in the fall of the year. PARENT/GUARDIAN(S) MUST COMMUNICATE MEDICATION NEEDS WITH KIDS CLUB, IF APPROPRIATE. *Written parental permission is required for all medications (prescription or over the counter). NOTE: No "ASPIRIN" or Aspirin containing products will be accepted for administration to students without authorization from a licensed prescribing practitioner.
- 4. All medication must be accompanied by specific instructions, when and how it is to be given, and for how manydays.
- 5. All medication must be kept in a locked cabinet and administered in the health office. Special exceptions to these circumstances may be made when approved and deemed safe by the Licensed School Nurse. Examples may be self- carry, IEP, 504, or health plan related issues.
- 6. **UNDER NO CIRCUMSTANCES** will school personnel provide any over the counter medication to students. Schools do NOT have stock medications.
- 7. All medication administered must be approved by the F.D.A., unless a licensed prescribing practitioner and a License School Nurse deems it medically necessary that it be administered during the school day.
- 8. Administration of each dose of medication shall be recorded on the student's electronic healthrecord.
- 9. Health staff will not send prescription medication home with a student unless pre-arranged with a parent. Any medication remaining in the health office past the end of the school year will be properly disposed of.

school your child attends (faxing is acceptable).								
SCHOOL	PHONE	FAX	SCHOOL	PHONE	FAX			
Armstrong	425-4102	425-4115	Cottage Grove Middle	425-6812	425-6828			
Bailey	425-4802	425-4815	Lake Middle	425-6412	425-6428			
Central Park	425-2711	739-1538	Oltman Middle	425-3511	425-3555			
Cottage Grove Elem	425-5802	425-5815	Woodbury Middle	425-4507	425-4567			
Crestview	425-3802	425-3815	SWAHS	425-7001	425-7015			
Grey Cloud	425-4202	425-4215	East Ridge High	425-2304	425-2307			
Hillside	425-4002	425-4015	Park High	425-3706	425-3705			
Liberty Ridge	425-5902	425-5915	Woodbury High	425-4403	425-4412			
Liberty Ridge Site II	425-7162	425-7165	Next Step	425-5106	425-5115			
Middleton	425-4902	425-4915						
Newport	425-4302	425-4315	**Kids Club – All Sites	425-6637	425-6620			
Nuevas Fronteras	425-3102	425-3115						
Pine Hill	425-3902	425-3915	DPC/ECSE	425-6162	425-6199			
Pullman	425-3602	425-3615						
Red Rock	425-5602	425-5615						
Royal Oaks	425-4702	425-4715	New Life	757-4330	459-6194			
Vallev Crossina	425-7502	425-7515	St Ambrose	768-3014	768-3080			
Woodbury Elem	425-4602	425-4615	Hope Christian Academy 459-6438 769-21					

NOTE: Medication will not be administered without proper authorization. OVER







MEDICATION / PROCEDURE FORM (SIDE 2)

ool:		Grade:			Date:	
	AUTHORIZATION FOR THE ADMINISTRA		•	TMENT		
<u>-</u>	orExchange ofHealth and EducationInforn					
•	quires authorization from the parent and FC)-Requiresauthorizationfromtheparen		are provide	r.		
ocedures at School:	re) – kequiresuutiioi izutioi ii oi ittiepui eii	•				
	cose monitoring *gastrostomy feeding *oxygo	en administration *b	lood pressur	e monitoring o	n a regular basis	
	LICENSED HEALTH CARE	PROVIDER AUTH	IORIZATIO	N		
Diagnosis & ICD 10	Medications/Procedure*	Dose	Time	Route	Possible Side Effects	
l.						
2.						
3.						
<u> </u>						
ther considerations/direction	s:		Start	Date:	Stop Date:	
•					•	
RINT NAME of Licensed Prescrib	er Signature of	Licensed Prescribe	er		Date	
inic Name/City	Pho	ne Number		Fax Num	ber	
. ,						
	-	DIAN AUTHORIZA				
• •	consent form is to authorize for the safe and use to sign, if you refuse, we will not be able	•	tration of m	edication and	treatment in school.	
 Information regardir 	ng this order will only be given to South Wasl		ool District 8	33 staff who n	eed this information to	
support the student	s education. th professional may release information to	and request inform	ation from S	outh Washingt	ton County School District	
related to the autho	•	una request inform	ution nom s	outri wasiiingi	tori Courity School District	
	onal staff may release information to and re	quest information fi	rom the pres	scribing health	professionalrelated to the	
	his authorization that has not been altered v	will be treated in the	same man	ner as the orig	inal.	
	th records, once received by District 833, mo protected by the Family Educational Rights			PAA, but they w	vill become	
	medication(s) be given during school hours			/sician/license	d prescriber.	
· ·	ol of any change in the medication(s). Exam	· ·				
 I give permission for 	the medication(s) to be given by school per	rsonnel as delegate	d by the sch	ool nurse.		
 The authorization ex 	pires at the end of each school year or after	summer schoolter	m.			
	individual and/or an emergency care plan					
	mmunication regarding the above health c may be in electronic form which could inclu		alcation with	rparent(s)/ga	dididi(s) as well as the	
DI FACE OLIFON ONE CETT		ION AT THE END OF	THE VEAR	ov po o diti c	-	
	E OPTIONS BELOW FOR RETURNING MEDICAT chool will be disposed of appropriately.	ION AT THE END OF	INE TEAK. A	y medications	5	
•	nedication from the health office by the end	of the last day of so	chool.			
Please send hon	ne all medication in my student's backpack	on the last day of so	hool.			
	ure Relat	ionship to Student				