Saint Paul Conservatory for Performing Artists

Medication Authorization and Administration 2024-2025

Student Name: _____

Birth date: _____ Grade: _

School staff administering medication will record time and initial as medication is given. Authorized Staff:
1._____
2._____
3._____

1. PHYSICIAN ORDER
FOR ADMINISTRATION OF MEDICATION BY SCHOOL
I have prescribed or authorized the following medication for this student and request that dosages be given during school hours.

_____ _____
Medication (one for per order) Dose

_____ _____
Time to be administered & Route PRN Repeat Frequency

Reason for medication: _____
Possible side effects: _____
Special Instructions: _____
Medication ALLERGIES: _____

Print Physician's Name: _____
Physician Signature: _____
Phone: ( )_____ Fax: ( ) _____

2. PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION
(PLEASE INITIAL THAT YOU HAVE READ AND AGREE WITH THE FOLLOWING STATEMENTS)

_____*I request this medication be given as prescribed.*
_____*I release the school personnel from any liability in the administration of this medication.*
_____*I understand that I am responsible for communications with health care providers ordering medications and will notify school of any changes.*
_____*I understand all medications must be transported to/from school by an adult.*
_____*I have checked that items will not expire during the school year.*
_____*I understand that the school does NOT have a NURSE on staff.*
_____*I give permission for the medication to be given by designated personnel.*

The physician and I agree that this medication is to go on field trips. ☐ *yes* ☐ *no*
I authorize my student to carry and self-administer his/her inhaler. ☐ *yes* ☐ *no*
I authorize my student to carry an epi pen. ☐ *yes* ☐ *no*

To promote safety for your child, medication orders may be shared with school personnel working with your student and with 911 personnel if needed.

Parent/Guardian Signature: _____
Phone ( ) _____ Date: _____

Parent/Guardians of students requesting that any **Prescription** or **Over the Counter** item to be administered during school hours by school staff are required to provide the school with:

A. Completed Physician's order
B. Completed Parental release
C. Medication supplied to office in original container and transported to/from school by adult

3. MEDICATION RECEIPT *(To be completed by school personnel)*	
Student Name:	**Birth date:**
Medication:	MVNA NOTES:
Date: _____ Count:_____	
Staff accepting medication: Parent Intls.	
Medication:	MVNA NOTES:
Date: _____ Count:_____	
Staff accepting medication: Parent Intls.	

SEE OTHER SIDE OF FORM FOR ADMINISTRATION RECORD

Initial on date when medication is given to student. See instructions for medication administration on other side of form.

AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24	24	24
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26	26	26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30		30	30	30	30	30
31		31		31	31		31		31		31