St. Cloud Area School District 742!
Prepare. Engage. Educate. Empower. Inspire.

District Administration Office
1201 South Second Street
Waite Park, MN 56387
P 320-370-8000
F 320-370-8003

Health Services Department
Return this form to your child's school nurse.

School Fax Numbers:

Apollo: 320-370-8946	North: 320-370-7224
Clearview: 320-370-6659	Oak Hill: 320-370-6174
Discovery: 320-370-6329	Quarryview: 320-370-8348
Kennedy: 320-370-7629	Roosevelt: 320-370-6939
Katherine Johnson: 320-370-7998	South: 320-370-7429
Lincoln: 320-370-6784	Talahi: 320-370-7899
Madison: 320-370-6504	Tech: 320-370-8649
McKinley: 320-370-6889	Westwood: 320-370-7779

HEALTH CARE PROVIDER AND PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION OR TREATMENT
Public and Non-Public Schools

The purpose of this consent form is to authorize safe and necessary administration of medication and treatments in school by parent/guardian and prescribing health care provider and authorize consultation between District 742 nursing staff and health care provider about the medication or treatment listed below. This form needs to be renewed each school year and whenever there is a change in medication, dosage and/or frequency.

- Parents/guardians will complete "Authorization for the Administration of Medication and/or Treatment" form (NS13.03) when a medication is brought to school, or within two school days of when verbal permission is provided.
- All medications, prescription or over the counter may only be administered at school when a health care provider order and a pharmacy labeled container is provided. The containers must have the same name of the student, name of the prescribing provider, name and dosage of the medication, directions for administering the medication at school and the date filled. Parents/guardians will be contacted if labeling is inadequate, or the prescription is outdated.
- Administration of medications/treatments will be completed by the licensed school nurse, licensed practical nurse or delegated District 742 personnel.

Health Care Provider Authorization for Medication/Treatment

Name of Student_____Student ID_____ Birthdate_____
School_____ Grade/Teacher_____ Grad Year_____
Name of Parent/Guardian(s)_____Phone Number_____
Name of Medication_____Dose and Route of Medication_____
Time of Day to be Given_____Possible Side Effects_____
*Diagnosis and ICD 10 Code_____
_____Student is not able to safely and properly self-carry medication at school
_____Student is capable to safely and properly self-carry medication at school
Termination date for administration_____, or August 31 of the current school year. The school year runs from September 1 through August 31.

Name of Health Care Provider_____Phone Number_____
Clinic Name_____ Fax Number_____
I give my permission for the above-named student to receive medication at school. I am aware that medication may be administered by a paraprofessional or assistant.

_____
***Signature of Health Care Provider** **Date**

Parent Authorization for Medication/Treatment

I hereby request the licensed school nurse, or other authorized personnel, to give medication as prescribed by a health care provider to the child described above. I release the school personnel from liability in the event any reaction results from the named medication. This authorizes the licensed school nurse to contact the health care provider for any further information needed regarding the medication or the condition being treated.

_____
Signature of Parent/Caregiver **Date**
Date of Verbal Permission by Parent/Guardian:_____ Date of Verbal Permission by LSN to Administer:_____

_____
Licensed School Nurse Approval Signature **Date**

NS 13.03 – 12/16/22