

**BRAHAM AREA PUBLIC SCHOOLS DISTRICT 314
HEALTH OFFICE
(320) 396-5210**

**PHYSICIAN ORDER AND PARENT AUTHORIZATION FOR MEDICATION FORM
MUST BE RENEWED ANNUALLY**

Student _____ date of birth _____

Parent/guardian _____

School (circle): Braham Area Elementary Braham Area Highschool Teacher/grade _____

PHYSICIAN ORDER

I request and authorize you to administer the following medication to the above named student:

Medication	dose	time	duration	diagnosis	Side effects

other medication student is taking _____

physician signature _____ date _____

print physician name _____ phone _____

clinic _____ fax _____

Comments:

PARENT/GUARDIAN AUTHORIZATION

- I request that the above medication be given to my child during school hours as ordered by this student's physician.
- I will immediately notify the school of any change in the medication or physician's order, dosage change, frequency, or duration of administration.
- I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.
- I give permission for the school nurse to consult with this child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
- I release all school personnel and I.S.D. 314 from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

Parent/guardian signature _____ date _____ phone#1 _____ #2 _____

- FIELD TRIPS-** I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
- I release all school personnel, I.S.D. 314 and any responsible adult administering the medication from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.**

Parent/guardian signature _____ date _____