PARKVIEW / ROOSEVELT ELEMENTARY SCHOOL / VIRGINIA SECONDARY SCHOOL

NURSING OFFICES PHONE: ROOSEVELT/HIGH SCHOOL 218-742-3918 PARKVIEW 218-742-3821 FAX # 218-741-8522

ROOSEVELT/ VIRGINIA HIGH SCHOOL 411 5TH AVE SOUTH VIRGINIA MN 55792
PARKVIEW LEARNING CENTER 506 N 9TH AVE VIRGINIA MN 55792

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NAME__________________________________BIRTHDATE______________ GRADE____________

I hereby request and authorize you to give:

Medication Dosage Time of Day

1. ____

2. ____

3. ____

Diagnosis/Medical reason for medication: ____
Other medications this student is taking: ____
Other recommendations/UNUSUAL side effects: ____

Physician's Signature ____________________________________ Today's Date _________________
Print Physician's Name ___________________________________ Phone ______________________
Clinic Name & Address ____ FAX _______________

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PARENT/GUARDIAN AUTHORIZATION:

1. I request that the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school of any change in the medication such as dosage changes, time changes or discontinuation and obtain the appropriate MD order.
4. I give permission for the school nurse to communicate with teachers about the action and side effects of this medication.
5. I give permission for the school nurse to consult the above-named student's physician or pharmacist regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication
6. Field Trips – I give permission for the assigned teacher or other responsible adult to dispense the medication on a field trip if necessary.
7. I agree to provide this medication in a container labeled by the pharmacy with the current prescription number and prescription date.
8. **By signing this form parent/guardians provide authorization for their child's health care provider noted above via medical records to send medical forms/information via fax, phone, or mail directly to the ISD 706 Virginia MN Public School Nurse requesting information.**

Signature of parent/guardian ____________________________________ Date ___________________

Relationship to student ________________________ Daytime phone number ___________________