_____ Daily     _____ As needed

Parents of a student requesting that medication be administered during school hours by school staff are required to provide for the school:  1) **the physician order**, 2) **a parental release** and 3) medication supplies in the **original medication bottle** (*you may ask the pharmacy for medication to be split between two labeled bottles*)**.**

Student name: _____    Date of Birth: _____

School: _____    Grade/Grad Year: _____    Teacher: _____

### Physician's order for administration of medication by school personnel

I have prescribed the following medication and request the dosages be given during school hours:

Medication: _____    Dosage to be given: _____

Unit dose (strength) provided: _____    Number of unit doses (e.g. tablets, liquid): _____

Time to be given: _____

For Treatment of: _____

Possible side effects: _____

Special Instructions: _____

Last date to be given: _____

Ok to self-carry?  (Inhalers, epinephrine pen, ibuprofen, acetaminophen)      Yes _____      No _____

Physician's signature: _____    Phone: _____    Date: _____

Physician's address or Clinic name: _____

### Parental request for administration of medication and release of information

Only when a medication is prescribed to be taken during school hours will a child be given medication at school.  I request this medication be given as prescribed and the above requested information be released to the physician from the school.   If necessary the school may request additional information from the physician regarding this medication/condition.

Ok to self-carry?  (Inhalers, epinephrine pen, ibuprofen, acetaminophen)      Yes _____      No _____

**Parent/Guardian signature:** _____Daytime phone: _____    Date: _____

| | | | |
|---|---|---|---|
| Minnetonka Middle School East Health Office | Phone | (952) 401-5210 | **FAX  (952) 401-4010** |
| Minnetonka Middle School West Health Office | Phone | (952) 401-5318 | **FAX  (952) 401-5350** |
| Minnetonka High School Health Office | Phone | (952) 401-5771 | **FAX  (952) 401-5728** |

| Date medication received | Unit Dosage | Count | Expiration Date | Initials of person receiving |
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**Initials**      **Signatures**                    **Initials**      **Signatures**

_____      _____        _____      _____

_____      _____        _____      _____

_____      _____        _____      _____

| Medication Administered | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Date | Time/Dose Administered | Initials | | Date | Time/Dose Administered | Initials | | Date | Time/Dose Administered | Initials |
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Rev. 4/17