MEDICATION PERMISSION FORM

School District #877 Buffalo – Hanover – Montrose

The BHM School District Medication Policy requires a licensed prescriber signature for all prescription medication and a parent/guardian signature on all medications given during school hours. By completing this form you are authorizing the health office to administer medications as directed in writing by you and/or your licensed prescriber for the school year.

*Medication must be sent to school in a current labeled prescription bottle or in the original over-the-counter container.

*Medication will be started when ALL REQUIRED signatures are received.

Name of Student: _____ **Birthdate:** _____

School: _____ **School Year:** _____ **Grade:** _____

Medical Condition/ ICD 10 CM	Medication	Strength (per tablet/ml)	Dose (total # of tablets or ml)	Time(s) Frequency	Route	Start Date	Stop Date

_____ _____

Print Name of Physician/Licensed Prescriber **Signature of Physician/Licensed Prescriber**

_____ _____ _____ _____

Clinic Name/City **Fax Number** **Phone Number** **Date**

(Exact dosage times of daily medications will be determined upon consultation with school nurse)

PARENTAL PERMISSION FOR MEDICATION ADMINISTRATION

I am giving permission to school personnel to administer medication and release them from liability in the event of reactions resulting in its use. In addition, I authorize health services to contact my student's clinic/licensed prescriber for the purpose of clarifying a medication order. I understand that my student's teacher may be consulted in regard to this diagnosis or medication usage to assure his/her safety. I agree to contact the licensed school nurse at my student's school in the event I do not want this information shared.

Parent/Guardian Signature _____**Date**_____

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Erica Kindt, Licensed School Nurse, Grades 6-8, 763-682-8211 or ekindt@bhmschools.org
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