BHM SCHOOLS
Buffalo Hanover Montrose

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 physician 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.

Student Name: _____ Birthdate: _____

School: _____ Grade: _____ School Year: _____

Medical Condition/ ICD 10 CM	Medication	Strength mg/ml	Dose # Tablets	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 the health service 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: _____

Karen Schultz, Licensed School Nurse, Grades 6-12, 763-682-8120 or kschultz@bhmschools.org
Heidi Gallart, Licensed School Nurse, Grades K-5, 763-682-8514 or hgallart@bhmschools.org