



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 (mg per tab/ml)	Dose total # tabs 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)

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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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