CAMBRIDGE ISANTI Schools
EVERY STUDENT, EVERY DAY

Administering Prescription Medications

Student Name_____ DOB_____

School_____ School Year_____ Grade_____

I am giving school personnel permission to administer medications to my child per the following Parent and/or Physician release.

Medical Condition	Medication	Strength/mg/ml	Dose	Time	Route	Start Date	End Date

(All Authorizations expire at the end of the school year or at the end of Extended School Year summer school programs)

Special Instructions:

Licensed Prescriber name_____

Signature of Licensed Prescriber_____

Clinic_____Phone/Fax_____

____My son/daughter may self-administer his/her inhaler/Epi-pen if appropriate as assessed by the School Nurse.

____This medication is a controlled substance. Parent/legal guardian is required to retrieve the drug/controlled substance when requested by the school.

I understand I am responsible to provide this medication in the original container and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. All unused medication is required to be picked up by the last day of school. By signing this form, I am authorizing the school district to transport and dispose of all unused medication in accordance with Minnesota Statues 152.01 subdivision 4.

Parent/Guardian Signature_____Date_____