



Parental Consent and Licensed Prescriber Authorization for Administering Prescription Medication

Instructions: Complete a separate form for each prescription medication. The Parent/Guardian must complete the top box, and the physician must complete the bottom box.

THIS FORM MUST HAVE A DOCTOR'S SIGNATURE

To Be Completed By Parent/Guardian

Student Name: _____ Date of Birth: ___ / ___ / ___

Allergies: _____

I am the parent or guardian of _____. I give my permission for appropriately trained Northstar Academy and/or Career Academy staff to administer the following medications to him/her during school hours. I hereby acknowledge that I have read, understand, and will abide by Northstar Academy's Student-Parent Handbook procedures relating to the transportation/handling of medications at school. I hereby release Northstar Academy and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of Northstar Academy to share information regarding this medication with the licensed prescriber below.

Parent/Guardian Signature

Daytime Phone

Date

Medication Authorization (For Use by Licensed Prescriber ONLY)

Relevant Diagnosis: _____ Medication/Strength: _____

Dose: _____ Route: _____ Frequency: _____

Duration of Administration:

- Short term (List dates to be given): _____
 For the duration of the current school year

A. Serious reactions can occur if the medication is not given as prescribed:

YES NO *If yes, describe:* _____

B. Serious reactions/adverse side effects from this medication may occur:

YES NO *If yes, describe:* _____

Action/Treatment for reactions: _____

Report to you: YES NO (*Attach Drug Information Sheet If Desired*)

Special Handling Instructions: Refrigerate Keep out of sunlight Other: _____

Asthma/Diabetes/Allergy Rescue Medications ONLY

This student is BOTH capable of and responsible for self-administering this medication:

YES- Supervised YES- Unsupervised NO

This student may carry this medication: YES NO

Licensed Prescriber Name (Please Print)

Licensed Prescriber Address/Phone:

Licensed Prescriber Signature

Date