

Student's Name \_\_\_\_\_ Age \_\_\_\_\_ Approx. weight \_\_\_\_\_

**LEGACY CHRISTIAN ACADEMY**

3037 Bunker Lake Blvd. N.W., Andover, Mn. 55304  
Phone: 763-427-4595, Ext 208 - Fax 763-427-3398

**MEDICATION ADMINISTRATION AUTHORIZATION**

Medications to be given at school require parental/guardian signature to administer. The number of pills, or amount of liquid medication must be recorded on an envelope in which the original bottle and medication is sealed and sent to Health Service. The medications are kept in Health Services for safety reasons.

Medications to be given more than 2 weeks require a medical providers order.

If the student is going to self-administer the medication (i.e. inhaler) the doctor will have to state, "okay to self-administer" on the doctor's order and a parent/guardian's signature is required on the form. A back-up supply of medication kept in health service is recommended to prevent your child from being without medication when he/she needs it.

Medication that requires three doses per day, should be planned so that two doses are given outside of school, unless otherwise ordered by the physician.

**Physician's Order**

I prescribed the following medication and request it be given during school hours.

Medication \_\_\_\_\_ Route \_\_\_\_\_  
Dosage/Time \_\_\_\_\_  
Start date \_\_\_\_\_ End date \_\_\_\_\_  
For treatment of \_\_\_\_\_

*Blood sugar testing for diabetes* - Yes \_\_\_\_\_ No \_\_\_\_\_

Unless specified below by the doctor, all medications will be kept in the health office.

**Doctor to list reason(s)** why a student is to carry & self administer medication

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As the child's physician, I authorize the school nurse to communicate with me regarding medication/treatment for this student.

\*\*\***Physician's signature** \_\_\_\_\_ Date \_\_\_\_\_  
Print Name \_\_\_\_\_ Clinic Phone: \_\_\_\_\_

**Parental Authorization**

I request this medication be given as prescribed and the above requested information be released to the school. I also give the school nurse permission to communicate with the doctor regarding this medication.

\*\*\***Parent signature** \_\_\_\_\_ Date \_\_\_\_\_