



## MEDICATION/PROCEDURE FORM (SIDE 1)

South Washington County Schools  
 Independent School District 833  
 OFFICE OF SPECIAL SERVICES  
 7362 E. Point Douglas Road S.  
 Cottage Grove, MN. 55016-3025

### DISTRICT PROCEDURES AND MINNESOTA GUIDELINES REQUIRE THE FOLLOWING:

1. Medications which are required during school hours and which the parent/guardian is unable to come and administer, must be administered by a school nurse or a designee whom the nurse has trained and delegated to, the function of medication administration.
2. NOTE: Medication to be given in the school is to be supplied in the original container/prescription bottle. A bottle of the medication should be prepared by the pharmacist, for school, with the appropriate labeling for school use.
3. \* Written parental permission and licensed health care provider permission are both required for all prescription medication.  
 \*Written parental permission is required for all medications (prescription or over the counter).  
 NOTE: No "ASPIRIN" or Aspirin PRODUCTS will be accepted from parents for administration to students without authorization from a licensed prescribing practitioner. A new authorization form must be completed annually in the fall of the year. **PLEASE SHARE MEDICATION NEEDS WITH KIDS CLUB, IF APPROPRIATE.**
4. All medication must be accompanied by specific instructions, when and how it is to be given, and for how many days.
5. All medication must be kept in a locked cabinet and administered in the health office. Special exceptions to these circumstances may be made when approved and deemed safe by the school nurse. Examples may be self-carry, IEP, 504, or health plan related issues.
6. **UNDER NO CIRCUMSTANCES** will school personnel provide aspirin or other over the counter medication to students from any school stock supply.
7. All medication administered must be approved by the F.D.A. Herbal dietary supplements are encouraged to be administered at home. Requests will be handled individually by a licensed school nurse.
8. Administration of each dose of medication shall be recorded on the student's medication record.
9. School nurses will not send prescription medication home with a student unless pre-arranged with a parent. Any medication remaining in the health office past the end of the school year will be properly disposed of.

**This form should be completed by parent and physician/ licensed prescriber, if necessary.  
 The form should be returned to the school your child attends (faxing is acceptable).**

SCHOOL	PHONE	FAX	SCHOOL	PHONE	FAX
Armstrong	425-4102	425-4115	Cottage Grove Middle	425-6812	425-6828
Bailey	425-4802	425-4815	Lake Middle	425-6412	425-6428
Central Park	425-2711	739-1538	Oltman Middle	425-3511	425-3555
Cottage Grove Elem	425-5802	425-5815	Woodbury Middle	425-4507	425-4567
Crestview/Nuevas Fronteras	425-3802	425-3815	SWAHS	425-7001	425-7015
Grey Cloud	425-4202	425-4215	East Ridge High	425-2304	425-2307
Hillside	425-4002	425-4015	Park High	425-3706	425-3705
Liberty Ridge	425-5902	425-5915	Woodbury High	425-4403	425-4412
Liberty Ridge Site II	425-7162	425-7165	Next Step	425-5342	425-5362
Middleton	425-4902	425-4915			
Newport	425-4302	425-4315	**Kids Club – All Sites	425-6637	425-6620
Pine Hill	425-3902	425-3915	DPC/ECSE	425-6162	425-6199
Pullman	425-3602	425-3615			
Red Rock	425-5602	425-5615	New Life	757-4330	459-6194
Royal Oaks	425-4702	425-4715	St. Ambrose	768-3014	768-3080
Woodbury Elem	425-4602	425-4615	Hope Christian Academy	459-6438	769-2108

NOTE: Medication will not be administered without proper authorization. OVER →



## MEDICATION/PROCEDURE FORM (SIDE 2)

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 Cottage Grove, MN. 55016-3025

Student \_\_\_\_\_  
 D.O.B. \_\_\_\_\_ School \_\_\_\_\_  
 Grade \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION/TREATMENT**  
**HIPPA – Compliant Authorization for Exchange of Health and Education Information**

**Medications at School:**

**\*Prescription Medications** – Requires authorization from the parent and licensed health care provider.

**\*Non-prescription Medication (OTC) – Requires authorization from the parent**

**Procedures at School:**

- \*bladder catheterization    \*blood glucose monitoring    \*tracheostomy care and suctioning
- \*gastrostomy feeding    \*oxygen administration    \*blood pressure monitoring on a regular basis

LICENSED HEALTH CARE PROVIDER AUTHORIZATION					
Diagnosis & ICD 10	Medications/Procedure	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					

**All other considerations/directions:** \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Signature of Physician/Licensed Prescriber	PRINT NAME of Physician/Licensed Prescriber	Date
Clinic Name/Address	Phone	Fax

**PARENT/GUARDIAN AUTHORIZATION**

1. The purpose of this consent form is to authorize for the safe and necessary administration of medication and treatment in school.
2. Legally, you may refuse to sign. If you refuse, we will not be able to provide service.
3. Information regarding this order will only be given to South Washington County School District 833 staff who need this information to provide your child's/adolescent's education.
4. The prescribing health professional may release information to South Washington County School District 833 professional staff and/or request information from District 833 professional staff related to the authorized service.
5. District 833 professional staff may release information to the prescribing health professional and/or request information from the prescribing health professional related to the service.
6. A photocopy/fax of this authorization that has not been altered will be treated in the same manner as the original.
7. I recognize that health records, once received by District 833, may no longer be protected by HIPPA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).
8. I request the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
9. I will notify the school of any change in the medication(s). Example: dosage change, medication is stopped, etc.
10. I give permission for the medication (s) to be given by school personnel as delegated by the school nurse.
11. The authorization expires at the end of each school year or after summer school term.

**Please check on of the options below for returning medication at the end of the year.** Any medications left the last day of school will be disposed of appropriately.

- I will pick up all medication from the health office by the end of the last day of school.
- Please send home all medication in my student's backpack on the last day of school.

\_\_\_\_\_  
 Parent/Guardian signature                                  Relationship to student                                  Date                                  Daytime phone