Permission Form for Medication in McLeod County Schools
This form must be used for each school aged child and renewed annually

<table>
<thead>
<tr>
<th>School</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glencoe-Silver Lake</td>
<td>☐</td>
</tr>
<tr>
<td>McLeod West</td>
<td>☐</td>
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<tr>
<td>Lester Prairie</td>
<td>☐</td>
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<tr>
<td>Hutchinson</td>
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<tr>
<td>Winsted/Howard Lake/Waverly</td>
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<tr>
<td>McLeod West/Waverly</td>
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<tr>
<td>New Century Charter</td>
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<tr>
<td>New Discoveries</td>
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</tbody>
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Student:____________________________________________________ Date of Birth/Age:____________________
Grade:____________________Teacher/Classroom:___________________________________________________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Reason for medication:__________________________________________________________________________
Name of medication:____________________________________________________________________________
Instructions (schedule and dose to be given at school):________________________________________________

<table>
<thead>
<tr>
<th>Start date</th>
<th>Stop date</th>
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<tbody>
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☐ For episodic/emergency events only

Restrictions and/or side important side effects:  ☐ None anticipated  ☐ Medication allergies
☐ Yes, please describe:________________________________________________________________________

☐ RE: GLUCOSE MONITORING
I am requesting that glucose monitoring be done during school hours.  Time of monitoring:____________
Instructions for monitoring:________________________________________________________________
This student is both capable and responsible for self glucose monitoring in the health office:
☐ No
☐ Yes, supervised

☐ RE: INHALERS/EPI-PENS
This student may carry his/her inhaler/epi-pen:  ☐ No  ☐ Yes
Physician assessment indicates this student has the knowledge and skills to safely self administer and
possess an inhaler at school:  ☐ No  ☐ Yes, supervised  ☐ Yes-Unsupervised

Physician Signature                                            Date
Physician’s Name (please print)
Clinic:____________________________________________________ Phone Number:__________________________

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (child’s name)______________________________________________________________
to receive the above medication at school according to standard school policy. I give my permission for the school
nurse to communicate with the student’s teachers about the student’s health condition(s) and the action of the
medications(s).

(All schools require parent/guardians to supply the medication in its original container.)

Signature                                             Date
Relationship to child:

Date form received by the school and initial:________________________________________

ADMINISTRATION OF THE MEDICATION WILL NOT NECESSARILY BE DONE BY A SCHOOL NURSE.