SWWC
EDUCATIONAL LEARNING CENTERS

Medication/Treatment Authorization Form

PARENT – PLEASE COMPLETE

Communication between the medical community and SWWC - ELC provides for positive health outcomes for children, families and community. Completion of this form and returning to the nurse at your child's ELC enhances coordination of services and promotes an optimal learning environment.

☐ Please fax this form to my child's nurse (Fax number: _____)

☐ I will provide this form to the nurse at _____ (please specify SWWC - ELC location) for the individualized treatment plan interval _____ to _____ (please specify time frame)

1. I request that the medication(s) and/or treatment(s)/procedure(s) specified on this form be given during SWWC - ELC hours as ordered by this child's physician/licensed prescriber.
2. I release SWWC - ELC personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).
3. I will provide SWWC - ELC with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)
4. I give permission for the nurse to communicate with the child's SWWC - ELC staff about my child's health condition (s) and the action of the medication(s) and/or treatment(s)/procedure(s).
5. I give permission for the nurse to consult (both verbally and in writing) with the above named child's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.
6. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designed personnel as delegated by the nurse.
7. I understand that school health personnel cannot administer the medication(s) /treatment(s)/procedures(s) indicated on this form without authorization from my child's physician/licensed prescriber.

Additional Information:

_____ _____ _____

Date Parent/Legal Guardian Signature Relationship to Child

Child's Name: _____ DOB: _____

Endorsed by the Minnesota Academy of Family Practitioners (MAFP) and the American Academy of Pediatrics, Minnesota Chapter. 2019-08-27 ML

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Communication Record Medication/Treatment Authorization Form

PHYSICIAN/LICENSED PRESCRIBER – PLEASE COMPLETE

Diagnosis/Significant Findings:

History:

Allergies:

Medication Required During School Hours					
Medical Condition	Medication	Strength	Time	Route	Possible Side Effects
1.					
2.					
3.					

**** Medication is to be supplied in the original manufacturer or prescription container. ****

Treatments/Procedures Required During School Hours (e.g., Peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes, etc.)			
Medical Condition	Treatment/Procedure	Time(s)/Frequency	Special Instruction
1.			
2.			

Diagnosis/Medical reason for medicine:

_____ICD-10-CM Code_____

_____ICD-10-CM Code_____

ADDITIONAL INFORMATION

☐ Child may carry/self administer his/her inhaler.

☐ Child may carry/self administer his/her epi-pen injector.

☐ Child may carry/self administer _____ (*Please identify*)

☐ Return to school with NO limitations on _____.

☐ REST AT HOME through _____ or until next scheduled visit.

☐ MODIFY the following activities during SWWC - ELC hours through _____ or until next visit.

☐ Physical Education ☐ Ambulation

☐ Sports ☐ Diet

Please specify:

_____ _____ _____

Date Print Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____ _____

Clinic Name and Address Telephone Number