MAWSECO PRESCRIPTION MEDICATION PERMISSION FORM

School Year: _____

USE SEPARATE FORMS FOR EACH MEDICATION!

Parent/Guardian(s): please pick up and drop off medications.

The MAWSECO Medication Policy requires a licensed prescriber signature for all prescription medication given during school hours. By completing this form you are authorizing the health office to administer medications as directed in writing by your physician for the school year.

*Medication will not be accepted if they are not in a **current** labeled prescription bottle. Please ask your pharmacy to label a separate school bottle. Please have an adult drop off/pick up medications or make arrangements through the school.

*Medication will be started when ALL REQUIRED signatures are received.

***Parent/guardian is responsible for making sure medications are refilled**!

School (check one) **Student ID: _____ (office use only)**

☐ Journeys ☐ TREK ☐ STEP ☐ Sholund ☐ Village Ranch ☐ Cornerstones ☐ Eastern Wright

Student Name:_____ **DOB**:_____ **Gr:_____ Teacher: _____**

PHYSICIAN MEDICATION ORDER **Information MUST be complete. Only ONE medication per form.**

Diagnoses & reason for medication:_____ **Allergies**:_____

Medication (Name & units/tab or mL):_____

(*Will be the end of school year if no stop date written.)

Dosage/How Often:_____ ***Stop Date:**___

For Epipens/Inhalers/Insulin Only Self-Carry: Yes: __ No: __ Self-Administer: Yes: __ No: __

Physician Signature:_____Date:_____

Print Name (Please print clearly): _____ Phone**:** _____

Name of Clinic:_____ Fax:_____

Address: _____

(Exact dosage times of daily medications will be determined upon consultation with licensed school nurse)

PARENTAL PERMISSION FOR MEDICATION ADMINISTRATION

I am giving permission to school personnel to administer medication and release them from liability in the event of reactions resulting in its use. In addition, I authorize the health service to contact my child's clinic/MD for the purpose of clarifying a medication order. I understand also that my child's teacher and designated staff may be consulted in regard to this diagnosis or medication usage to assure his/her safety. I agree to contact the school nurse at my child's school in the event I do not want this information shared. I agree to pick up at the end of the school year or the medication will be discarded.

Parent/Guardian Signature:_____**Date**:_____

Phone Number where you can be reached: _____

MAWSECO CONTACT INFORMATION:

MAWSECO Ed Center:
Journeys/TREK/STEP
720 9th Ave, Po Box 1010
Howard Lake, MN 55349
Phone: 320-543-1122

Cornerstones / Eastern Wright
1405 3rd Ave NE
Buffalo, MN 55313
Phone: 763-682-6440

Med Rec'd: Yes or No (Circle) Rec'd on _____ Exp. Date: _____ No. of pills/other: _____

Revised: 10/2018/jjh