

TrekNorth High School

2518 Hannah Ave NW
Bemidji, MN 56601

E-mail address: www.treknorth.org
Phone: (218)-444-1888
Fax: (218)-444-1893

Medication Form

Student Name: _____ **Grade:** _____

Parent/Guardaian: _____ **Phone:** _____

Prescription Medication:

Parents/guardians of students requesting prescription medications to be given to their child during school hours by school staff are required to provide the school with the following:

- 1, The doctor's order (one of the following meets the requirement).
 - a. Note from doctor
 - b. Copy of the prescription
 - c. Order section of this form filled out by doctor
2. Written parent consent for school to give medication to their child.
3. Medication supplied in the original pharmacy labeled bottle.

Physician Order (copy of prescription may be attached here)

I have prescribed the following medication for this child and request it be given during school hours.

Medication: _____ **Dosage/Time:** _____

For Treatment of: _____

Special instructions/possible side effects: _____

Physician Signature: _____ **Date:** _____

Parent Request for Administration of Prescription Medications.

_____ I request this prescription medication to be given as prescribed by the doctor.

Parent Request for Administration of Non-Prescription Medications.

_____ I request this non-prescription medication to be given to my child. (Please enclose the medication in the original manufacturer's package labeled with your child's name.)

Name of Medication: _____

Dosage and Time: _____

For Treatment of: _____

How long to be given: _____

Parent Signature: _____ **Date:** _____

New Forms must be submitted each school year. Medications will be administered by authorized staff member.