Post Falls School District #273
School Nursing Services
206 W. Mullan Ave, Post Falls ID
83854 PO Box 40, Post Falls, ID 83877
(208) 773-6976

Dear Parent or Guardian,

We strongly encourage that all medications be given at home whenever possible; yet, we understand that at times it is necessary to administer medication in the school setting. For the safety of your child as well as the general school population, we have developed the following guidelines:

- A medication authorization form must be completed and signed by the parent or guardian. A physician's signature is required if the instructions differ from the prescription label.
- All medications must be transported to and from school by the parent or guardian and never sent with the student.
- Medications (prescription and over the counter) must be in their original container. The container must be labeled with the student's name, the name of the medication, the dosage and the time to be administered. An extra prescription bottle may be prepared for school at the pharmacy.
- If the prescription changes, new authorization form must be provided to the school.
- All medication will be stored in the school office.
- The student is responsible for coming to the office to receive their medication.

If you have any questions, please call Elizabeth Costin, BSN, RN at the Post Falls School District nursing office (208) 773-6976.

Thank you,
Post Falls School District Nursing Services

Authorization for Medication Administration

Student's Name_______________________________________Birthdate_______________

Address____Home Phone_____________

Parent/Guardian Name_________________________________Work Phone_____________

School___________________________Grade________Teacher______________________

1. Physician's Name__________________________Phone#_________________
2. Name / Type of Medication____
3. Dosage / Amount to be given____
4. Frequency / Times to be administered__________________________________
5. Possible reaction of Medication (symptoms, side effects, etc)________________

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Parent/Guardian Request / Approval:

I certify that I am the parent or guardian of the above-named student. I request and authorize school personnel to dispense the above-named medication in accordance with the prescription or Doctor's orders.

Parent/Guardian Signature______________________________Date___________________

Physician's Signature__________________________________Date___________________

(Only required if medication is not in original prescription container or if medication exceeds normal dose range).