**School District of Elmwood**

**Authorization to Administer Medication**

**213 S. Scott Street, Elmwood, WI 54740**

**Phone: (715) 639-2711 / Fax (715) 639-3110**

**Student Name: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_ \_**

**Grade/Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**

**Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­ \_\_\_\_\_\_ Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**

I/We: • give consent for school personnel to administer the following medications according to the directions below •consent to the free exchange of information regarding this medication between the licensed prescriber/physician and school personnel •agree to notify the school in writing of any changes or termination of this request • understand that the medication must be delivered to the school in the original over-the-counter package detailing instructions for medication administration including student name, drug dosage, time/frequency •understand that any unused medication must be picked up at school by me/us in the school office •understand any medication not picked up by the last day of school will be disposed of by school personnel • agree to hold school personnel harmless in any and all claims arising from the administration of this medication at school or school related event •understand that this medication order is in effect for the current school year only

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| --- | --- | --- | --- | --- | --- |
| **NON-PRESCRIPTION MEDICATIONS** | | | | | Condition under which medication should be given: |
| Medicine Name | Route | Dose | Frequency/Time | Duration |
|  |  |  |  | From:  To: |  |
|  |  |  |  | From:  To: |  |
|  |  |  |  | From:  To: |  |

**Parent/Guardian Signature: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PRESCRIPTION MEDICATIONS - \*\*Physician Signature Required** | | | | | Direct contact with the physician shall be made for the following reasons: |
| Medicine Name | Route | Dose | Frequency/Time | Duration |
|  |  |  |  | From:  To: |  |
|  |  |  |  | From:  To: |  |

According to school policy, no prescription medication will be administered to a student without written medication orders from parent and physician. These orders must include the name of the drug, dosage, frequency/time to be administered, length of time medication is to be administered, reason medication is prescribed and conditions under which contact with the physician should be made. These directions and all of the above directions will be followed for all prescription medications.

I am prescribing medication for the above named student who has a diagnosis of: **\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Licensed Prescriber/Physician Signature: \_\_\_\_\_\_\_ Date: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescriber/Physician Name: \_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**

**Office/Clinic Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**APPROVAL FOR STUDENT CARRYING AN INHALER and/or Epi-Pen**

This student has received instruction and has demonstrated competency in the use of a metered dose inhaler or Epi-Pen (circle). He/She may carry and self-administer as prescribed. YES NO

**Licensed Prescriber/Physician Signature: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_­\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_ \_\_ Date: \_\_\_\_\_\_\_\_\_ \_­\_\_**