Prescription Medication Authorization Form
Barron Area School District

Student Name: _____ Date of Birth: _____ Grade/Teacher: _____

School: _____ School Phone: _____ Fax: _____

Parent Name: _____ Daytime Phone: _____

I/We: • give consent for school personnel to administer the following medications according to the directions stated by the above named licensed prescriber/physician. •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 or prescription package detailing instructions for medication administration including student name, drug dosage, time/frequency to be administered and physician name. •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.

***Parent/Guardian Signature:** _____Date: _____

Prescriber/Physician Name: _____ Phone: _____

Office/Clinic Address: _____Fax: _____

DAILY MEDICATIONS					Direct contact with the physician shall be made for the following reasons:
Medicine Name	Route	Dose	Frequency/Time	Duration	
				From: To:	
				From: To:	
				From: To:	

PRN (as needed) MEDICATIONS					Condition under which medication should be given:
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.

I am prescribing medication for the above named student who has a diagnosis of: _____

_____

***Licensed Prescriber/Physician Signature**: _____ Date: _____

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/Epi-Pen (circle). He/She may carry and self-administer as prescribed. ____ YES ____NO