

Policy Number: 453.4-Exhibit(3)

Title: PARENT PERMISSION FOR ADMINISTERING MEDICATION

Revised: January 20, 1997
May 17, 2010
October 15, 2012

**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.

Prescriber/Physician Name: _____ Phone: _____

Office/Clinic Address: _____ Fax: _____

Parent/Guardian Signature: _____ Date: _____

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: _____

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

Licensed Prescriber/Physician Signature: _____ Date: _____