Authorization to Administer Medication / Procedure Consent Form

School District of Superior

All prescription medication dispensed at school, including students who carry and self-administer Inhalers / Epi-Pens **must** have written instructions signed by the practitioner **and** the parent/guardian. **Non-prescription** medications require the written instructions signed by the parent/guardian only.

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

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 named licensed prescriber/physician 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 or prescription package detailing instructions for medication administration including student name, drug dosage, time/frequency to be administered and physician/licensed prescriber name *understand that any unused medication must be picked up at school by me/us in the health 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 events * understand that this medication order is in effect for the current school year and potential summer school year only.

Parent/Guardian Signature: _____Date:_____

DAILY MEDICATIONS

Medicine Name	Route	Dose	Frequency/Time	Direct contact with the physician shall be made for the following reasons:

PRN (as needed) MEDICATIONS

Medicine Name	Route	Dose	Frequency/Time	Condition under which medication should be given:

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: _____
_____

Prescriber/Physician Name: _____Phone:_____

Office/Clinic Address: _____Fax:_____

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

Licensed Prescriber/Physician Signature: _____Date:_____

The only medication the School District of Superior allows to be self-administered is Inhalers and Epi-pens. (WI Stat 118.291 & 118.292). Dev. 7/2013