DeForest Area School District

Authorization to Administer Non-Prescription Medication Form

Student Name: _____ DOB:_____Grade/Teacher _____
School:_____ School Phone:_____ Fax:_____

PRN (as needed) MEDICATIONS

Medication	Route	Dose	Time	Duration-if no end date entered, will remain valid until end of school year	Condition under which medication should be given
				From: To:	
				From: To:	
				From: To:	
				From: To:	

I: ➤consent for school personnel to administer the above medications according to the directions stated by the manufacturer ➤consent to the free exchange of information regarding this medication between the licensed prescriber/physician and school personnel ➤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, and time to be administered ➤understand that any unused medication must be picked up at school by me in the school office. ➤understand that any unused medication not picked up 10 days after the end 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/form is in effect for the current school year only.

Parent/Guardian Name: _____ Phone:_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____Date: _____