# DeForest Area School District

## Authorization to Administer Prescription Medication Form

Student Name: ______________________ DOB:__________ Grade/Teacher _____________
School:____________________ School Phone:__________________ Fax:_________________
Diagnosis/Diagnosis Code: ________________________________________________________

I: ➤give consent for school personnel to administer the below medications according to the directions stated by the prescriber/physician➤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 prescription package detailing instructions for medication administration including student name, drug dosage, time to be administered and physician name ➤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 (medication will not be sent home with student) ➤ 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 Signature: _________________________________ Date: ________

**DAILY MEDICATIONS**

| Medication | Route | Dose | Time | Duration - if no end date entered, will remain valid until end of school year | Direct contact with the physician shall be made for the following reason. |
|---|---|---|---|---|---|
| | | | | From:<br>To: | |
| | | | | From:<br>To: | |

**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:<br>To: | |
| | | | | From:<br>To: | |

According to school policy, no prescription medication will be administered to a student without written medication orders from a licensed physician and consent of parent/guardian. These orders must include the name of the drug, dosage, frequency/time to be administered, length of time medication is to be administered, and conditions under which contact with the physician should be made.

Licensed Prescriber Signature: _____________________________Date: ______________

Prescriber Name:_______________________Phone:____________ Fax: _______________

School Nurse Signature: _________________________________ Date: ________________