801 Second Street
Port Edwards, WI 54469
Phone: 715-887-9000
www.pesd.k12.wi.us

Authorization to Adminster Prescribed Medication

Name of Student____________________________ Date of Birth:___________Grade_______

I give permission for my son/daughter to receive prescription medication during school hours and during school sponsored activities/field trips that occur after hours. I will be responsible for

1. Delivery of medication in a pharmacy -labeled container to the school office
2. Maintaining a sufficient supply of medication
3. Keeping school personnel informed of changes in the medication (dosage,time)
4. Obtaining a new form from the prescribing physician for any changes in this medication

I hereby release the board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication

Signature____ Date___________

Physician Order

I am prescribing medication for ________________________ which is as follows:

Name of Medication	Dosage	Form	Time	Possible adverse Side Effects

For Metered Dose inhalers and Epi-pens only:
This patient has received instruction and has demonstrated competency in the use of the above medication. He/She may carry and self-administer as prescribed.

Physician Signature______________________________

I understand the above information may be shared with necessary school personnel. The above order shall remain in effect through the end of the current school year unless discontinued or changed by me or the parent/guardian withdraws the request in writing.

Physician Name___________________________ Phone_______________
Physician Signature_________________________ Date ________________

At the end of the school year please (circle one): **Contact me to pick up remaining medication**

Dispose of remaining medication **Send medication home with my student**