

Port Edwards Public Schools

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John Edwards Middle & High School FAX: 715-887-9040

www.pesd.com

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION PARENTAL CONSENT

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

Names of Parent(s)/Guardian: _____

Phone: (Home) _____ (Work) _____

I give permission for my son/daughter to receive prescription medication during school 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.

(Parent/Guardian Signature)

(Date)

PHYSICIAN ORDER

I am prescribing medication for _____ which is as follows:
(Patient's Name)

Name of Medication (Generic and Trade)	Dosage (mg/cc/tsp/gtt)	Form* (tab/cap/liq.)	Time a.m./p.m.	Possible Adverse Side Effects

FOR METERED DOSE INHALER ONLY:

This patient has received instruction and has demonstrated competency in the use of a metered dose inhaler. He/she may carry and self-administer the inhaler as prescribed.

Physician's 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's Name: _____ Phone: _____
(Please Print)

Physician's Signature: _____ Date: _____
(No Stamp)

Authorization to administer Prescribed Medication

For School Use Only

1. Date Received: _____

2. Name of Person(s) who will administer the medication:

3. Approved by _____
(SCHOOL NURSE)

(DATE)