SHIOCTON SCHOOL DISTRICT HEALTH SERVICES

Parent and Medical Provider Authorization Form

Prescription Medication Given At School

Student: _____ Grade: _____ D.O.B.:_____

Parent: _____

Address: _____Phone: _____

Physician: _____ Clinic: _____Phone: _____

Dear Parent/Guardian:

The Shiocton School District is required by state statute to give prescription medication to students only with complete directions from a medical provider and signed consent by parent/guardian.

Medical Provider:

The following is to be completed by the child's medical provider prior to administration at school. Please indicate if the medication is a PRN drug and under what conditions the drug should be given and repeated.

Name & dose of medication	Route	Amount to be given	Approx. time	Duration of medication	Side effects

_____ _____

SIGNATURE OF MEDICAL PROVIDER **DATE**

PARENT:
I request that my child be assisted by designated school personnel in taking the medication described above at school as authorized by me and my physician. Specific questions/concerns may be communicated to the physician by the Registered Nurse serving the school.

I further agree to hold the Shiocton School District and all employees harmless in any and all claims arising from the administration of this medication at school.

As the parent or Guardian of the above mentioned student, I will keep the school district aware in writing of any changes in the medication(s) profile or health concern of my child.

****ANY MEDICATION BROUGHT TO SCHOOL MUST BE IN THE ORIGINAL LABELED CONTAINER****

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

NOTE: Any change in medication will require a new form. For year long medications, prescription will expire at the end of each school year.